
# No belladonna backfire...

## when you relieve nervous indigestion with.....

BENTYL

Clinical [1,2,3] and pharmacological results show that the dual action of BENTYL (musculotropic, neurotropic) provides complete and more comfortable relief than that of all other antispasmodics tested.

**DOSAGE:** Two capsules three times daily, before or after meals. If necessary, repeat dose at bedtime.

**BENTYL** ..... 10 mg
*for comfortable relief of nervous indigestion*

**BENTYL** ..... 10 mg
with **PHENOBARBITAL** ..... 15 mg
*when synergistic sedation is desired*

1. Hock, C.W.: J. Med. Assn. Ga. 40: Jan., 1951
2. Hufford, A.R.: J. Mich. St. Med. Soc. 49:1308, 1950
3. Chamberlin, D.T.: Gastroenterology 17: Feb., 1951

Trade-mark "Bentylol" Hydrochloride

Merrell 1828

New York — CINCINNATI — Toronto

# Medical Economics

* * * *July 1951* * * *



[CONTINUED ON FOLLOWING PAGE]

## Contents [*Continued*]



DEPARTMENTS



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CCA

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NBP

# "Therapeutic" bile

In biliary tract disorders bile itself can be "therapeutic" – when the bile flow evoked is abundant and fluid, serving to flush the biliary tree of mucus, pus, particulate matter and thickened bile.

Bile of this "therapeutic" character – copious in volume and low in viscosity – is produced by the specific hydrocholeretic action of *Decholin* and *Decholin Sodium*. These agents are especially valuable in nonsurgical drainage therapy of chronic cholecystitis, noncalculous cholangitis and biliary dyskinesia, and before and after surgery of the tract.

Adequate dosage of *Decholin* for most patients requires one or two tablets three times daily for 4 to 6 weeks. Prescription of 100 tablets is recommended for maximum efficiency and economy. More prompt and intensive hydrocholeresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc., intravenously, once daily.

# Decholin and Decholin Sodium

*Decholin* (brand of dehydrocholic acid)
Tablets of 3¾ gr. in bottles of 100, 500, 1000 and 5000.

*Decholin Sodium* (brand of sodium dehydrocholate)
20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc., in boxes of 3, 20 and 100.

*Decholin* and *Decholin Sodium*, trademarks reg.

AMES

**AMES COMPANY, INC · ELKHART, INDIANA**

Ames Company of Canada, Ltd., Toronto

D-7

Binding covered by U.S. patent No. 2,193,334

—

*In specified territories.

*For* **HIGH** *Pollen Levels–*

**HIGH**

**Antihistaminic Potency**

Neo-Antergan is characterized by high antihistaminic potency—and a high index of safety. It affords prompt, safe, symptomatic relief to the allergic patient during distressing periods of high pollen levels.

Neo-Antergan is *available on prescription only*, and is advertised exclusively to the medical profession.

* * *

*Available in coated tablets of 25 mg. and 50 mg. in bottles of 100, 500, and 1,000.*

*The Physician's Product*

# NEO-ANTERGAN®

MALEATE

(Brand of Pyrilamine Maleate)
(Formerly called Pyrrobutamine Maleate)

COUNCIL ACCEPTED

MERCK & CO., INC.
*Manufacturing Chemists*
RAHWAY, NEW JERSEY

# proved brighter

In developing Radelin Screens, the United States Radium Corporation decided not merely to provide *another* line of X-ray screens but a *better* line of screens. Recently completed scientific, impartial tests* of the Radelin Fluoroscopic Screen FG *prove* it affords greater brilliance than other fluoroscopic screens. Moreover, it provides good contrast, fine detail, and is long-lived.

Other outstanding screens in the Radelin line are Photofluorographic Screens PF (blue) and PFG (green), which offer the optimum combination of speed and detail, with negligible afterglow.

The significant characteristics of an X-ray screen are determined by the quality of its phosphor (fluorescent chemical). The United States Radium Corporation has been developing and manufacturing high-quality phosphors for a quarter century and is a leading supplier of phosphors to science and industry.

When you order X-ray or photofluorographic equipment, or replace screens, make sure you get the advantages of these products by specifying "Radelin Screens."

## Radelin-FG
## FLUOROSCOPIC X-RAY SCREEN

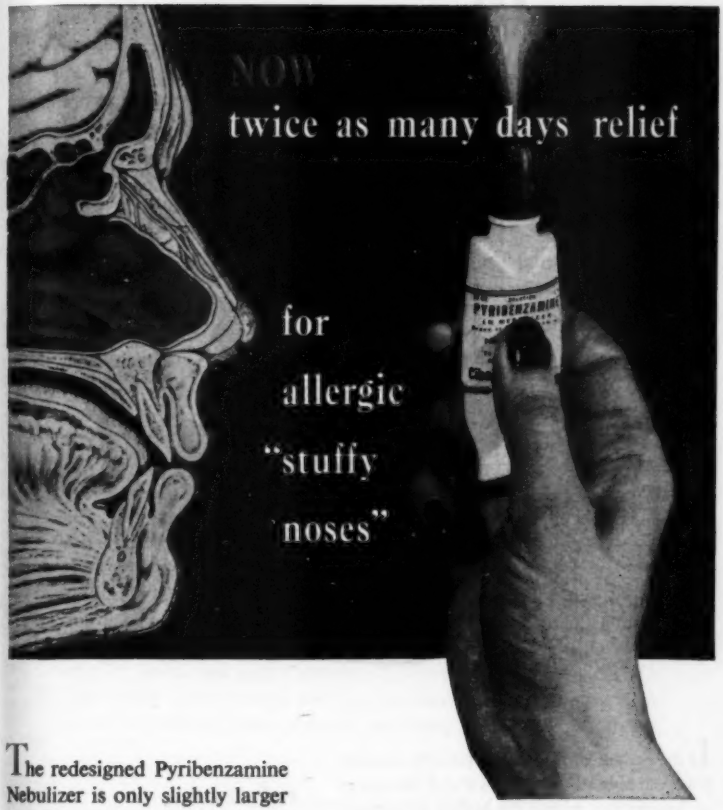
*Conducted by two well known, independent laboratories.

US RADIUM

*Radelin Division*

**UNITED STATES RADIUM CORPORATION**

**535 Pearl Street, New York 7, N. Y.**




The redesigned Pyribenzamine Nebulizer is only slightly larger than the original one but holds twice the quantity of Pyribenzamine Nasal Solution 0.5%.

A mist of the potent antihistaminic Pyribenzamine® (tripelennamine) hydrochloride is distributed by the Nebulizer throughout the nasal passages. Relief is usually prompt and prolonged, with virtually no possibility of systemic side effects.

# New Pyribenzamine Nebulizer

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, N. J.

2/1644R

# When temptation passes too often

If the patient's will-power is notably unstable, it's a valuable adjunct that will dull the pangs of hunger and relieve the feeling of frustration which is often the underlying factor in overeating. Such is DESOXYN Hydrochloride. With DESOXYN *smaller dosage* is possible because, weight for weight, it is more potent than other sympathomimetic amines. One 2.5-mg. or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. With DESOXYN you can expect a *low incidence of side-effects*, plus *faster action* and *longer effect*. Try it—in obesity and in all other conditions indicating an effective central stimulant.

Abbott

*Prescribe*

**DESOXYN®**

*Hydrochloride*

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

# Panorama

Kinsey hoax being repeated, this time in Maryland, where housewives complain that a fake "Dr. Fontaine" phones and asks sexy questions . . . Hospitals that need structural steel for building or remodeling now limited to 25 tons except by special authorization of National Production Authority . . . Blood for armed forces in Korea flowed from medical arteries when members of New York County medical society lined up for wholesale donation to Red Cross.

Woman-hating M.D.'s" employing "prejudice and propaganda" to keep petticoated anesthetists out of OR, says Mrs. Josephine Bunch, vice president of American Association of Nurse Anesthetists. Alleged result: a shortage of 10,000 anesthetists, a serious increase in surgery deaths . . . Nation's 1949 mortality rate from TB was 26.2 per 100,000 population, a 9 per cent drop from 1948 . . . Tennessee news editors hailing new press-radio code drafted by Nashville Academy of Medicine and Davidson County (Tenn.) Medical Society. Code goes beyond previous standards by outlining specific rules for medical-press contacts, reporting emergency cases, etc.

Arraigned for practicing medicine without a license, retired street cleaner David Feldheim told a Bronx, N.Y., magistrate, "It's only hypnosis." He said a mail-order course he had taken left him "gifted with healing powers." His fee for administering same: $50 for three treatments. Female investigator who took treatments said Feldheim "ran his fingers up and down my spine." He called her "receptive" . . . American Board of Legal Medicine takes its place in galaxy of medical examining agencies. Its aims: to elevate standards of medical testimony, draft legislation on medical matters, certify diplomates as medico-

# NEW

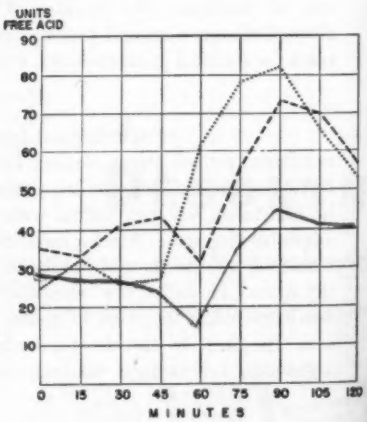
## Resin-gastric mucin combination

*in peptic ulcer management**

*combines*

"...the good effects of resins with those of gastric mucin in the treatment of gastroduodenal ulcer"*

"...the admixture of gastric mucin enhances the antacid effect of the resins..."*




.....Histamine.

———Histamine and Anion Exchange Resin and Mucin Combination, 4 Tablets.

———Histamine and Anion Exchange Resin and Mucin Combination, 2 Tablets.

IN A FIVE YEAR controlled study* recently completed at the gastrointestinal clinic of a large Chicago hospital, comparative tests were made of available antacids in the treatment of gastroduodenal ulceration.

Various resinous substances were tested including "the new type of 'antacid' "—Resmicon—a synergistic combination of a finely dispersed ion-exchange polyamine resin with a specially processed form of gastric mucin.

Resmicon was given to a series of patients over a period of 2 to 15 months. Most of the patients chosen were those who did not respond well to therapy with other antacids.

**EFFECT ENHANCED**—The investigators confirmed their previous findings** namely that "the admixture of gastric mucin enhances the effect of the resins."

**QUICK RELIEF**—"Most patients had good symptomatic relief within the first week (2 to 7 days) of 'Resmicon' treatment . . . .

"They felt better, ate better and gained weight. The majority took the tablets well and there were no complaints regarding constipation or diarrhea."

**HEALING ENCOURAGED**—"Simultaneously with clinical improvement the patients with gastric ulcer showed significant changes in the size of the craters when x-rays were taken at weekly or bi-monthly intervals.

"Those who were gastroscoped (a total of 19) also showed healing of the ulcer."

"This new substance [Resmicon] appears to combine the good effects of resins (neutralization of the hydrochloric acid in gastric juice without interfering with the acid-base balance) with those of gastric mucin in the treatment of gastroduodenal ulcer."

# Resmicon®

ACID ADSORBENT DEMULCENT • 84 TABLETS

*Steigmann, F., and Schlesinger, R. B.: A Resin-Gastric Mucin Mixture in the Medical Management of Peptic Ulcer, American J. Dig. Dis. *17*:361-365 (Nov.) 1950.

**Scientific Exhibit of the A. M. A., Atlantic City Session, 1949.

Whittier

**LABORATORIES**

DIVISION NUTRITION RESEARCH LABORATORIES, INC.
CHICAGO 11, ILLINOIS

legal experts . . . Four times as many marriages as divorces took place in 1950, latest figures show. Divorces declined for fourth straight year.

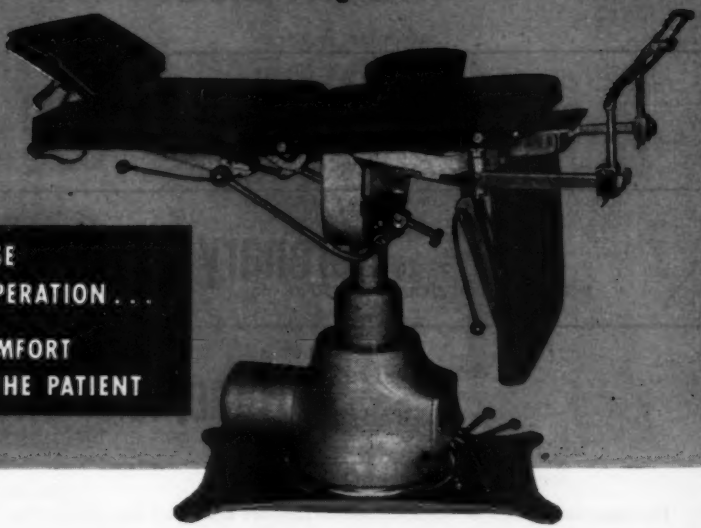
Convinced that M.D.'s can't be taught penmanship, Dean Roy Anderson Bowers of University of New Mexico College of Pharmacy trains pharmacy students to decipher bad writing. With 35 mm. microfilm projector, he shows collection of 200 cryptic Rx's . . . Tally by states of organizations that have gone on record against compulsory health insurance shows Indiana is most vocal, with 2,098 protests. That's twice as many as next-ranking state, West Virginia, with 944.

Shakedown of staff physicians during hospital fund-raising campaigns condemned in resolution passed by New Jersey medical society . . . "Atomikits" of first-aid materials for atomic casualties now being assembled in quantity, to sell for about $10 wholesale. They're said to meet requirements of Civil Defense Administration . . . Doctors' needle-less hypodermic now matched by dentists' drill-less drill, which gets its effect with stream of compressed air containing abrasive aluminum oxide particles.

Top-echelon maneuvers: Maj. Gen. George Ellis Armstrong nominated as Surgeon General of the Army. Maj. Gen. David Grant, wartime Air Force Surgeon General, named American Red Cross medical director and head of ARC's National Blood Program. Dr. W. Randolph Lovelace 2nd of Albuquerque, N.M., appointed chairman of Armed Forces Medical Policy Council, succeeding Dr. Richard L. Meiling . . . Chicago's Committee of Fifteen has capped 44-year fight against prostitution with its best success story yet: Committee headquarters closed for lack of business.

Bogus M.D. gave Washington, D.C., constabulary the slip after making notations on hospital patient's chart . . . Rising cost of hospitalization under scrutiny at both

# he New Ritter Specialists Table



EW EASE
OF OPERATION . . .
EW COMFORT
FOR THE PATIENT

ANOTHER outstanding table in the new Ritter line of Multi-Purpose tables, the Ritter Specialists Table, Model B, Type 8, is designed primarily for the doctor whose practice requires a general examination and treatment table, but specializes in either gynecology or urology. Like all Ritter Tables, a minimum of effort is required for adjustment. Table tilt is controlled by hand-operated friction lock (foot tilt optional). The Specialists Table is easily adjusted to any required position from full horizontal to chair. Patients are brought up to convenient examining level quietly, rapidly, smoothly by a motor-driven, hydraulically elevated base. The Specialists Table has a low position of 26½". and high position of 44½". Table tilts 45° head low. Exclusive Ritter designed automatic locks on head, back, seat and front sections assure ease of positioning and full security. Rotates 180° on sturdy base which prevents accidental tilting. Stirrups are completely concealed when not in use. Patients enjoy the comfort of resilient sponge rubber cushions with vinyl coated nylon fabric covers.

The Ritter Specialists Table is equipped with adjustable headrest, perineal cut-out, stainless steel irrigation pan and retractable stirrups. Optional equipment at slight additional cost includes explosion-proof motor, arm board support, side rails, knee crutch set, strap hanger crutch set and hand wheel operated gear tilt mechanism. Available also in foot pump base.

**VISIT YOUR RITTER DEALER FOR A DEMONSTRATION NOW**

FOR ADVANCED EQUIPMENT LOOK TO **Ritter**

COMPANY INCORPORATED
RITTER PARK, ROCHESTER 3, N.Y.

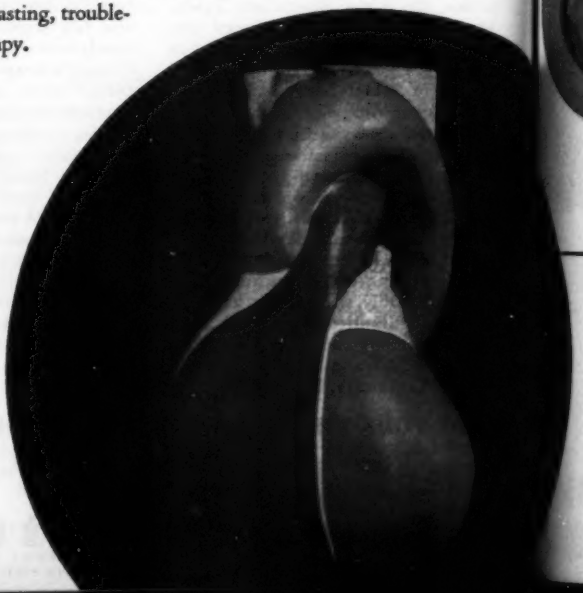
# without distraction

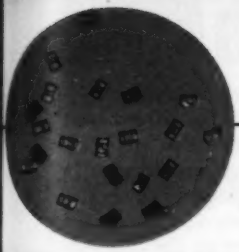
## in Cardiac Decompensation

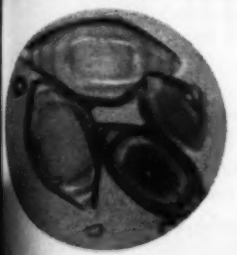
## in Coronary Disease

## in Hypertension

The superior features of theobromine therapy are now available without the side-effects which drive doctors to distraction. Maltbie research has produced an unique double salt of calcium theobromine and calcium gluconate—Calpurate, for longer lasting, trouble-free theobromine therapy.







## *Seeing is believing*

Calpurate is *really* different. Convincing evidence may be seen at a glance in the accompanying polarized photomicrographs. Compare the rectangular crystals of theobromine (top), and the needle-like crystals of calcium gluconate (middle), with the double-salt crystals from a solution of Calpurate (bottom).

## *In clinical practice, too*

Seeing is believing . . .

Calpurate affords sustained myocardial stimulation, vasodilation and diuresis without gastric disturbances. Calpurate with Phenobarbital relieves stress and improves circulatory efficiency, exerts a desired calming effect.

Administration and Dosage: 1 or 2 tablets t.i.d.

***Maltbie Laboratories, Inc.,*** Newark 1, New Jersey

# Calpurate • Tablets and Powder

Theobromine Calcium Gluconate Maltbie

# Calpurate

with **Phenobarbital** • Tablets

***for trouble-free, prolonged cardiac therapy***

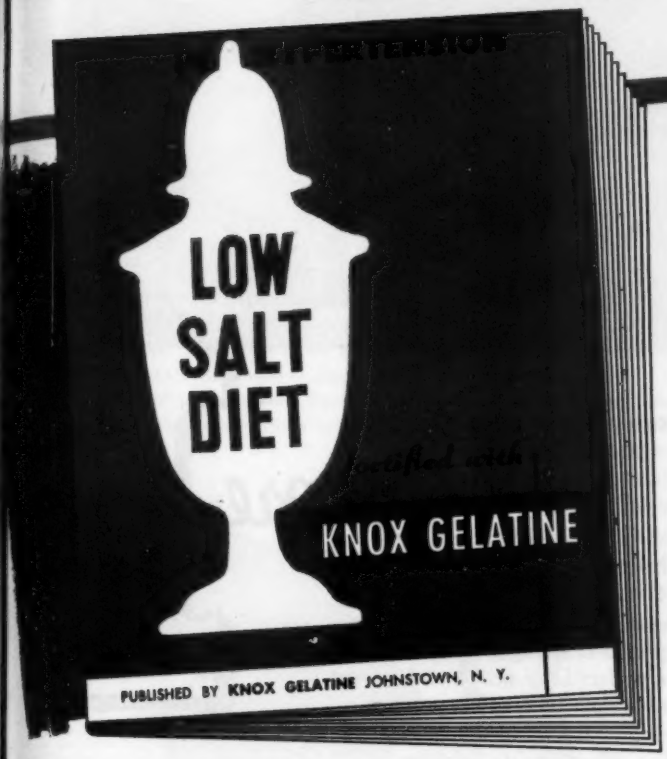
ends of line. Consumer concern voiced by Harry Becker, UAW-CIO social security director, who foresees possible "20 per cent or more" increase in next eighteen months, urges that voluntary insurance leaders meet with labor. Doctor concern reflected in Rhode Island where state medical society sees hospital rate boosts as threat to existence of voluntary plans and has named citizens' group of twenty-three to seek a solution.

For "strait-jacketing" ninety-two physicians in administrative jobs, V.A. has taken tongue-lashing from Congressmen . . . Evangelical Deaconess Hospital, Lincoln, Ill., cancels maternity charges for babies born there on Mother's Day . . . Common interest in scientific and technical aspects of blood banks has attracted 725 members to American Association of Blood Banks, representing forty-six states and nine foreign countries. Fourth annual AABB meeting is scheduled for Minneapolis in October . . . A Rochester (Minn.) child, accustomed to meeting only M.D.'s and their wives, called his doctor-daddy aside at social function to ask, "What's a mister?"

Ratio of medical officers to men in Army reported as 3.6 per 1,000, or little more than half World War II high of 6.8: 1,000. Navy figure: 4.8; Air Force, 2.8 . . . Colorado Health Department jolted by death certificate filed by doctor with this comment on cause of patient's death: "Alcoholism led to poverty. Welfare department gave him too little to keep him alive and that he spent on booze. Lack of coal led to freezing in a shack too cold for a hog. Pneumonia mercifully put an end to his long life in hell and sent him back to heaven where he came from."

Watch the birdie: In Cullman, Ala., Pharmacist J. A. Leith Jr. has lined walls of his store with photos of local doctors; he says customer enjoys recognizing physician who has just written prescription, sometimes forgets to complain about price. In Warsaw, Mo., Dr. Guss C. Salley rushes from delivery room, grabs Polaroid Land camera, a minute later delights mother with picture of her scion.

# New BROCHURE . .
## YOURS ON REQUEST



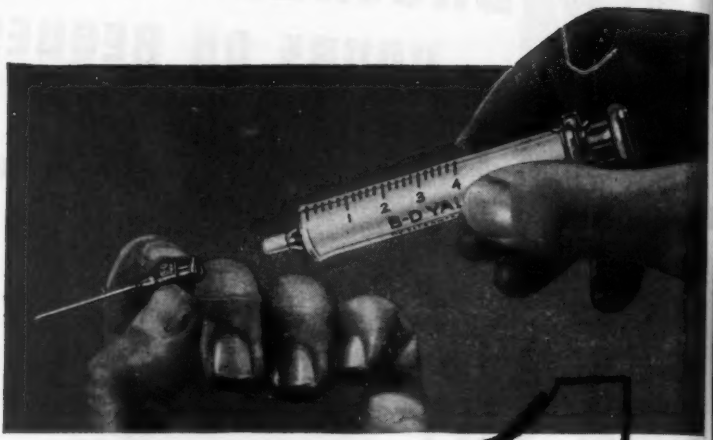

**JUST OFF THE PRESS!** An attractively illustrated brochure with helpful-to-the-patient do's and don'ts, and economical, tempting recipes utilizing high-protein, low-sodium Knox Unflavored Gelatine.

**WRITE TODAY FOR YOUR FREE COPY!** It's "must" reading—designed to assist you in the control of hypertensives.

KNOX GELATINE, Johnstown, N. Y., Dept. ME

**KNOX GELATINE U.S.P.**

ALL PROTEIN NO SUGAR




**You can prevent a score** against your budget if you always use a B-D needle with a B-D syringe.

score...!

**The hub of a B-D needle** is drilled, reamed, and micrometer-gauged for depth, diameter, and pitch to fit the tip of B-D syringes. Anything less than a perfect fit of needle and syringe not only causes leakage but produces a scoring of the tip of the syringe which soon leads to tip breakage.

Always use a B-D needle with a B-D syringe and you'll prevent a score against your budget.

B-D PRODUCTS
*Made for the Profession since 1897*

**BECTON, DICKINSON AND COMPANY, RUTHERFORD, N.J.**

# SYNDROX

(METHAMPHETAMINE HYDROCHLORIDE, Ayerst)

ACCEPTED
COUNCIL ON PHARMACY AND CHEMISTRY
AMERICAN MEDICAL ASSOCIATION


McNE

# "36 miles to 'walk off' one pound of adipose tissue"

It takes a 36-mile hike, state Rehfuss et al,* to rid the body of only one pound of surplus fat.

"Current thinking," report these authors, "tends to the belief that, excluding overweight caused by faulty elimination (salt retention), all cases of obesity are the result of eating more than is required to meet the energy requirements of the body."

When curbing the appetite is indicated—to overcome the added burden which fat puts on the body—Syndrox is an efficient means of suppressing the desire for food.

In addition to depressing the appetite, Syndrox produces a sense of well-being which is particularly helpful where overeating is due to a psychic factor—frustration, depression, etc.

**SYNDROX**

- . . . suppresses appetite
- . . . elevates the mood
- . . . counteracts drowsiness and feeling of fatigue
- . . . imparts a sense of increased energy and efficiency

Syndrox has a rapid onset of action (10-20 minutes); long duration of effect (6-12 hours, depending on dose); negligible side effects, with proper dosage; small dosage requirement.

*Goldfine, M. E. et al: A Course in Practical Therapeutics, Baltimore, The Williams & Wilkins Co., 1948, p. 162.

SUGGESTED INITIAL DOSE: 2.5 to 5 mg. daily; dosage may be increased to 2.5 to 5 mg. two to three times daily and maintained at this level as long as there are no untoward effects.

SUPPLIED in 5 mg. tablets (scored, green), bottles of 100 and 1000. Also available in a pleasant-tasting elixir (colored amber); each 30 cc. (1 fl. oz.) containing 20 mg.—pints and gallons.

Samples on request.

to-day

it's the

# parentoral way

Just one or two tablets daily—
plus an occasional injection

Just one or two Tablets MERCUHYDRIN with Ascorbic Acid daily — plus an occasional injection of MERCUHYDRIN Sodium — keep the average cardiac edema-free. For convenience, safety, effectiveness prescribe

*tablets*

# MERCUHYDRIN

*with ascorbic acid*

**oral mercurial diuretic**

**the simplest method of outpatient maintenance**

To secure the greatest efficacy and *all* the advantages of Tablets MERCUHYDRIN with Ascorbic Acid, a three-week initial supply should be prescribed... 25 to 50 tablets.

**DOSAGE:** One or two tablets daily — morning or evening — preferably after meals.

**AVAILABLE:** Bottles of 100. Each tablet contains meralluride 60 mg. (equivalent to 19.5 mg. mercury) and ascorbic acid 100 mg.

M-19

Lakeside Laboratories, INC., MILWAUKEE 1, WISCONSIN

# *Speaking Frankly*

## Prosperity

SIRS: Your recent editorial, "Is Your Prosperity Showing?" seems to suggest that it is dishonorable for anyone in the medical profession to give the impression of prosperity. No one admires a person who is ostentatious, but why is it disgraceful for a doctor to drive a Cadillac? Buicks and Chryslers may cost just as much, and no word is said against the owner of these.

After spending nineteen years in training, a doctor should be able to show some degree of prosperity without your inane criticism.

M.D., West Virginia

SIRS: "Is Your Prosperity Showing?" dealt with a subject that needs more stress. Thanks for having the courage to call it to our attention.

Harry Q. Gahagan, M.D.
Alexandria, La.

## Bureaucracy

SIRS: Dr. Paul Magnuson was unceremoniously discharged as chief medical director of the Veterans Administration. So what? Am I to be surprised that a bureaucracy isn't as interested in patients as in bureaucrats?

It seems to me much more important that we know why such a distinguished gentleman as Dr. Magnuson ever went into the V.A. Why must men of his medical stature be so frequently deluded that they can become part of a bureaucracy and at the same time avoid the evils inherent in bureaucratic government?

Dr. Magnuson states that the question is simply this: Shall veterans' hospitals be run by doctors or bureaucrats?

But Dr. Magnuson *was* a bureaucrat. Why should he have become voluntarily a type of person he deplores? He must have fallen into the error of thinking that there can be such a thing as a *good* bureaucracy—this in spite of an unholy number of examples to the contrary.

John K. Glen, M.D.
Houston, Tex.

## Non-Participation

SIRS: We can be thankful that some of the views regarding nonparticipation and the Association of American Physicians and Surgeons [April MEDICAL ECONOMICS] are shared by only a minority of physicians.

We can ignore the defeatists, but it is appalling to find prominent

## A Dexamyl Case History

**The unique value of Dexamyl* in providing symptomatic relief from mental and emotional distress is clearly demonstrated in this case history—from the file of a Philadelphia general practitioner.**

Patient: B.H. (shown in photos on opposite page), age 46, married, the mother of a 16-year-old son. She has financial security and "no real cause for worry", but she "enlarges the simple vicissitudes of life until they become great anxieties".

The patient is mentally alert and has a fair sense of humor, but even this does not free her from her "moods" and apprehensiveness. "Her aches and pains are legion." She has frequent headaches attributable to the early menopausal syndrome. Most of her pain centers in the back along the spinal column. X-rays show osteoarthritic areas.

Her main complaint: morning depression and irritability.

Medical treatment: Dexamyl — 2 tablets after breakfast and 1 tablet after lunch.

Results: "Dexamyl ... ironed out the morning so that the early hours were more tolerable. It soothed her anxieties; her son's boyish ineptitudes were made understandable; her household duties became less burdensome. Morning living became more livable."

# Dexamyl

a balanced combination of 'Dexedrine'* and Amobarbital, Lilly (Amytal†)

Each tablet contains 'Dexedrine' Sulfate, 5 mg.; Amobarbital, Lilly ('Amytal'), ½ gr. (32 mg.)

*Trademark S.K.F. †Trademark Lilly

Smith, Kline & French Laboratories, Philadelphia

These candid photographs of Patient B.H.—snapped unbeknown to her—were taken during an interview in her physician's office. This study of the patient describing her symptoms of mental and emotional distress forms an interesting complement to the case history on the opposite page.

physicians so unaware of the nature and significance of professional responsibility. These range from the anti-intellectual who would reject non-participation without even bothering to analyze it, to the naive souls who think collectivized medicine can really be made to work.

Even more appalling is the apologetic, shame-faced attitude toward taking a firm stand on moral principle. As physicians, we accept a trust from each patient. We have pledged ourselves to place his welfare above every other consideration—to brook no interference in the exercise of our best professional judgment in his behalf. We have agreed, by implication, to submit to no authority which may curtail our freedom to fulfill this trust.

We can be proud, and need never fear, to let it be known that neither threats nor bribes can make us betray the interests of our patients. The quoted public relations director who thinks otherwise should be made to understand this —or should be promptly dismissed.

It is as simple as this: "He who holds the purse strings calls the tune." When "society" pays the medical bills of the individual, it also dictates what may be done for that individual.

When the doctor accepts such payment, he is accepting a bribe to betray his patient. No amount of sophistry can make it otherwise. The mere fact that patients, individually or by vote, ask or insist that he do so cannot relieve him of guilt. They do not know the implications of what they ask. But the doctor does know—or *should*.

Opposition to non-participation denotes ignorance or totalitarian leanings, or both. That is why "Education for Freedom" is the primary AAPS aim. That is why it *should* be a primary aim for every doctor.

F. B. Exner, M.D.
Seattle, Wash.

## Booby

SIRS: Permit me to compliment you on the article, "Statistics—Handle With Care!" It is an excellent presentation of a subject that should be taken to heart by physicians.

I have just one criticism:

The authors illustrate the article's point only too well by falling into a common booby-trap in the field of TB statistics—saying that the dangerous age for the disease is adolescence and young adulthood. This popular misconception is doing more to retard tuberculosis control than anything else.

C. W. Dewey, M.D.
Chapel Hill, N.C.

*Dr. Dewey is quite right in his remark that "the dangerous age for tuberculosis" is a misleading term and should be withdrawn from circulation. Tuberculosis has changed from a disease whose greatest death toll was among young adults to one*


there is RELIEF

# from "intractable" asthma

The unique blocking action of ACTHAR against complex manifestations of hypersensitivity has been well-established. For the patient with severe, intractable asthma, ACTHAR produces most gratifying results; the threat of asthmatic attacks can be minimized.

Status asthmaticus which has defied all other therapeutic attempts may yield quickly to relatively small doses of ACTHAR.

Definite and often dramatic improvement of the patient makes ACTHAR therapy a truly economic measure in the difficult management of severe asthma.

**ACTHAR Dosage.**—***Initial Dose:*** Less severe cases, 12.5 mg. q. 6 h. Severe, chronic cases, including status asthmaticus, may require up to 25 mg. q. 6 h. The initial dose should be continued from 2 to 4 days or longer in severe cases. ***Tapering of Dose:*** When symptoms have been controlled, decrease dosage 5 mg. per injection every other day until a total of 10 to 12 days of therapy has been given. ***Maintenance Therapy:*** May be required in severe, chronic asthma; 10 to 20 mg. once or twice per day.

Literature and directions for administration of ACTHAR, including contraindications, available on request.

ACTHAR is available in vials of 10, 15, 25 and 40 I.U. (mg.). The Armour Standard of ACTHAR is now accepted as the International Unit; 1 International Unit is identical with 1 milligram of ACTHAR.

# ACTHAR

**THE ARMOUR LABORATORIES**

CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

# When the diagnosis is Prostatitis

## First:

consider


to establish and maintain urinary antisepsis...

The value of MANDELAMINE* as a urinary antiseptic in the chemotherapy of prostatitis is based on (1) its wide antibacterial range, (2) exceptional freedom from drug-fastness—MANDELAMINE retains its therapeutic potency even against organisms which have become resistant to other antibacterial agents, (3) absence of untoward reactions in nearly all patients, and (4) simplicity of regimen.

Lowsley and Kirwin[1] recommend methenamine and mandelic acid in prostatic disease, especially when resistance or intolerance excludes the sulfonamides. A daily dose of 2.25 Gm. MANDELAMINE provides the antibacterial potency of 12 Gm. mandelic acid or 4 Gm. methenamine. Moreover, since MANDELAMINE approximates the sulfonamides and streptomycin in effectiveness, it may be used *first* whenever the diagnosis is prostatitis.

Other indications for MANDELAMINE are pyelitis, pyelonephritis, nonspecific urethritis, and infections associated with urinary calculi or neurogenic bladder; also valuable for pre- and postoperative prophylaxis in urologic surgery.

MANDELAMINE is available in bottles of 120, 500, and 1,000 enteric-coated tablets through all prescription pharmacies. Literature and samples to physicians on request.

1. Lowsley, O. S., and Kirwin, T. J.: Clinical Urology. Baltimore, Williams & Wilkins Company, 1944; vol. 1, p. 939.

NEPERA CHEMICAL CO., INC.
*Pharmaceutical Manufacturers*
NEPERA PARK, YONKERS 2, N. Y.

*MANDELAMINE is the registered trademark of Nepera Chemical Co., Inc., for its brand of methenamine mandelate.

*for which the death rate increases with advancing age.*

*Yet tuberculosis is still the leading cause of death among the relatively few who die between the ages of 15 and 34. It is a less important cause of the more numerous deaths in older age groups. This was the point made in the article cited.*

## 3-to-2

SIRS: Your article, "A Well-Rounded, Sensibly Priced Life Insurance Plan," does a disservice to your readers. It advises the doctor to arrange to have his National Service Life Insurance paid in cash so that his widow can bank the $10,000.

NSLI can better be worked into an insurance program by using one of the policy's various income options. These guarantee 3 per cent interest. They are based on an ancient annuity table in which costs are ridiculously low by today's standards.

If the doctor wants his widow to bank $10,000 of life-insurance proceeds, why doesn't he set aside $10,000 of his decreasing-term insurance for this purpose? This has an interest guarantee of 2 to 2½ per cent at best and does not have the favorable annuity options of NSLI. Would you cash a bond that paid 3 per cent and hold a 2 per cent one?

Frederick B. Northrup Jr.
Syracuse, N.Y.

*Mr. Northrup is right about the 3 per cent interest and the liberal settlement options of NSLI. We should agree with him that, instead of NSLI, any other* permanent-value *life insurance might be used to provide a widow with a lump sum.*

*But level-premium, reducing-term insurance cannot be set aside in advance to produce a specified lump sum since its value reduces monthly as long as the insured lives. If a doctor dies shortly after taking out the reducing-term policy, its lump-sum value for his widow may be considerable; but years later it is most likely to be less than the $10,000 required; at age 60, the commuted value of $100 a month is $5,584.56.*

## Leases

SIRS: About your recent article, "Goodbye to Private Practice!" A landlord cannot *force* rent payments under a lease after the physician is called into military service, can he?

M.D., Texas

*Yes, he can, unless the lease has a military clause. But a debt moratorium protects service men. Collection of rent can't legally be forced till the tenant returns to civilian life. So usually the landlord agrees to break the lease on the most favorable terms possible and get another tenant (preferably one over military age!).*

# Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

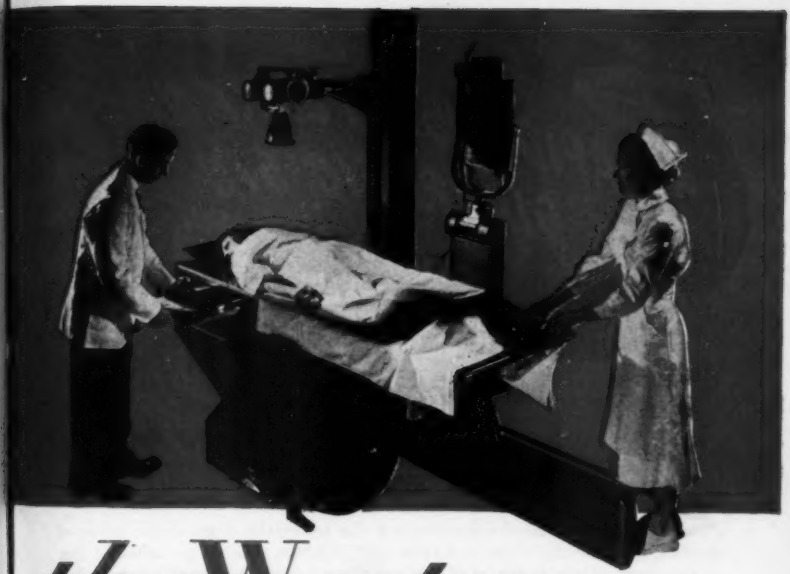
In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

**MARTIN H. SMITH COMPANY**
**150 LAFAYETTE STREET, NEW YORK 13, N. Y.**

## ERGOAPIOL (SMITH) *with* SAVIN

**The Preferred Uterine Tonic**



# *the Westex...*

**FOR PRIVATE PRACTICE, CLINIC AND HOSPITAL** The Westex, today's finest value in X-ray equipment, offers a complete range of radiographic and fluoroscopic techniques. The unit's features—separate floor-rail tubestand, high flexibility, maneuverability, compactness—ensure maximum utility.

SINGLE TUBE • TWO TUBE • HAND ROCK • MOTOR DRIVE

Westinghouse representatives, solely concerned with X-ray equipment, will be pleased to consult with you; they are uniquely competent in analyzing needs, space, and budget requirements. For a conference and a fully informative booklet, call your representative or write to Westinghouse Electric Corporation, 2519 Wilkens Ave., Baltimore 3, Md.

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# Westinghouse

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**MEDICAL X-RAY**

DUOFLEX · DUOCONDEX · SERVICE · ACCESSORIES

# RAPID DISAPPEARANCE OF DIARRHEIC STOOLS

*permitting*
*early re-alimentation and hydration*
*by the oral route*[1]

Recent studies[1,2] have demonstrated the unusually dependable value of Arobon in acute diarrheas of infants and children. Within a matter of one to two days, in the majority of patients the stools thicken and lessen in frequency. Thus early re-alimentation and hydration by the oral route and earlier resumption of normal feeding are possible.

Arobon, processed from carob flour, owes its pronounced anti-diarrheal activity primarily to its high content of lignin as well as pectin. Absorbing a considerable amount of water, it swells to a bland, smooth, bulky mass in the intestine, which eliminates offending bacteria and toxins with the stools, thus causing the diarrhea to subside quickly.

Arobon is indicated in all types of diarrhea in infants and children. It is palatable and readily tolerated. Arobon is ready for use by merely boiling it in water for ½ minute.


1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, J. Ped. *35*:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, Texas State J. Med. *46*:675 (Sept.) 1950.


THE NESTLÉ COMPANY, INC.
COLORADO SPRINGS, COLORADO

# Arobon®

*SPECIALLY PROCESSED CAROB FLOUR*
*HIGH IN PECTIN*
*AND LIGNIN*


The only broad-spectrum antibiotic available in concentrated drop-dose potency, Crystalline Terramycin Hydrochloride Oral Drops provide 200 mg. per cc.; 50 mg. in each 9 drops. Indicated in a wide range of infectious diseases, Terramycin Oral Drops are miscible with most foods, milk and fruit juices, affording optimal ease and simplicity in administration.

***Supplied*** | *2.0 Gm. with 10 cc. of diluent, and calibrated dropper.*

ANTIBIOTIC DIVISION **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

# Sidelights

## Ethical Quandary

In a recent letter to this magazine, an Indiana physician raises a troublesome question: "What should a doctor do when he sees a patient being treated improperly by a colleague?"

Under the A.M.A.'s old code of ethics, there was nothing the doctor could do. But in the 1949 revision something new was added—something that has an important bearing on this problem. Here's the key passage:

"A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession . . ."

Note that word "incompetent." It did not appear in the old code. It means that an ethical practitioner is now expected to speak up, instead of standing silently by, when he becomes aware of a colleague's slipshod treatment.

This does not, of course, mean broaching the matter to the patient. In any such situation, prudence suggests the following steps:

*1. Get the facts straight.* There's a difference between incompetent conduct and an honest mistake. Better be sure you're not jumping to conclusions before raising the issue in the first place.

*2. Take the matter up privately with the doctor concerned.* Almost any conscientious practitioner will listen to helpful advice if it's offered in a friendly spirit. Says the A.M.A. ethics code: "In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow."

*3. As a last resort, refer the matter to your medical society.* Says the A.M.A. code: "Questions of [incompetent] conduct should be considered, first, before proper medical tribunals in executive sessions . . ."

We don't pretend that this is an easy course to follow. But beyond all doubt, it's the ethical course. What's more, it's increasingly accepted as such—as witness the growing number of cases referred to medical society grievance committees *by physicians.*

## Medical Infiltration

Friction between physicians and social workers is a chronic complaint in many a U.S. community. But not where the medical men have acted

on the old precept: "If you can't beat 'em, join 'em."

In one city we know about—Columbus, Ohio—the two professions get along swimmingly. One reason, we suspect, is that the top local organizations in the social-planning field have been markedly infiltrated by M.D.'s. The Metropolitan Health Council, for example, is headed by Dr. Frances Harding; every important chairmanship is held by a physician. The Council of Social Agencies is headed by an internist's wife; the vice president is Dr. Thomas Rardin.

Suggest anything for *your* town?

## Political Forecast

The stirring political campaign that doctors engaged in last fall is having far-reaching repercussions. You won't hear anything official about it for some months yet, but we can tell you this:

A number of professions and industries are ready to band together in a massive election-year campaign against all forms of state socialism. Their target will be the national candidates who lean toward schemes like compulsory health insurance. Their techniques will be those exploited so successfully by the medical profession last year.

We have talked to some key figures in this prospective alliance. They hail the doctors' 1950 achievements as a mere sample of what can be done in 1952. "It won't be easy," one man told us, "getting fifteen or more different profession

# when "eating for two" ... plenty of citrus fruits

Most obstetricians today insist that their mothers ingest plenty of vitamin C, particularly after the first trimester[1] (8 oz. citrus juice during pregnancy, 12 oz. while lactating).* When an adequate nutritional regimen (with particular reference to vitamin C) is followed throughout pregnancy, toxemia is reduced[2]—more babies are born normally and with a higher birth weight[3,4]—premature and still births are fewer[3,4]—and both maternal and infant health are improved postpartum.[5] Most mothers enjoy the flavor of fresh Florida citrus fruits (so rich in vitamin C and containing other nutrients*), as well as the energy pick-up provided by their easily assimilable fruit sugars.[6]

* * *

**Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.*

**FLORIDA CITRUS COMMISSION**
LAKELAND, FLORIDA


**References:**

1. Burke, B. S. and Stuart, H. C.: J.A.M.A., 137:119, 1948. 2. Burke, B. S. et al.: Am. J. Obst. & Gynec., 46:38, 1943. 3. Burke, B. S. et al.: J. Nutrition, 26:569, 1943. 4. Javert, C. T. and Finn, W. F.: Texas State J. Med., 46:745, 1950. 5. McLester, J. S.: Nutrition and Diet in Health and Disease, Saunders, Phila., 4th ed., 1944. 6. National Research Council: "Recommended Food and Nutrition Board, Daily Allowances for Specific Nutrients," Wash., D. C., 1948. 7. People's League of Health: J. Lancet, 2:10, 1942.


**FLORIDA**
***Oranges • Grapefruit***
***Tangerines***

and big businesses to work together. But the doctors went into this thing cold and came out with a .900 batting average. We hope to achieve similar results on a far broader scale."

The people behind this coalition aren't saying much until they get a better look at the line-up of candidates—including Presidential candidates. But the odds seem better than even that their campaign will come off as planned.

Looks as if doctors will soon be in politics again—and this time with plenty of help.

## Guard Those Gams!

One thing about being an editor is that practically everything comes your way in time. One that recently came ours was a mail-order advertisement for "Gamguards." "Begin protection where raincoats leave off!" said the ad. "You'll have no mud-spattered legs—no creaseless trousers!" The photo showed something that looked like clear plastic shinguards, tidily encircling each leg. They clamped on to the crease of the wearer's trousers, just above the knee.

Naturally, we got to thinking what a jim-dandy thing these would be for the average mud-spattered, creaseless M.D. on his rainy-day house rounds. We can see him now, stepping jauntily out into the downpour, a nattier chap altogether than he used to be. As he hurries down Main Street, feminine eyes glance admiringly at those spotless, knife-

# For soundness in the infant's formula . . . check all


Sound example of three-dimensional structure in infant feeding is LACTUM, Mead's evaporated whole milk and Dextri-Maltose® formula.

1. *Milk protein* supplies 16% of Lactum's calories—a generous amount for growth and development.
2. *Milk fat* contributes 34% of the calories.
3. *Carbohydrates* supply 50% of the calories—ample for energy and proper fat-metabolism, and to spare protein for tissue-building functions.

Authoritative pediatric recommendations support this caloric distribution. With these approximate proportions, cow's milk–Dextri-Maltose formulas have been used successfully for 40 years.

**Lactum's 4th dimension . . .**

**Time-saving convenience**

Simply add water. A 1:1 dilution of Lactum provides 20 calories per fluid ounce.


MEADS

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U. S. A.

# PALATABLE PRESCRIPTION PRODUCT COMBINES 3 ENTEROACTIVE DRUGS FOR IMMEDIATE CONTROL OF DIARRHEA

## Immediate Control

Immediate control of diarrhea is considered essential—not merely to make patients comfortable and eliminate the nuisance of frequent stools—but also *to prevent severe losses of body fluids and electrolytes* and *to protect against complications.*

## Localized Action

For these purposes, CREMOSUXIDINE® is unusually well qualified: it contains *Sulfasuxidine®* (succinylsulfathiazole), the well-known "intestinal" bacteriostat, together with *pectin* and *kaolin*, two well-established intestinal adsorbents and detoxicants. These three therapeutic agents are admirably suited to "localized treatment" of diarrheas because their activities are largely confined within the lumen of the bowel. The use of "enteroactive" CREMOSUXIDINE thus makes it possible to avoid needless *systemic* action, and to maintain effective *local* concentrations of antibacterial and antidiarrheal agents in the areas where they are most urgently needed.

## INDICATIONS

For diarrheas in general

bacillary dysentery
paradysentery
salmonellosis
diarrhea of the newborn
"summer diarrheas"

For preoperative preparation to reduce risk of peritonitis
(in patients about to undergo abdominal surgery)

For postoperative management to speed convalescence
(after abdominal surgery)

## DOSAGE RECOMMENDATIONS

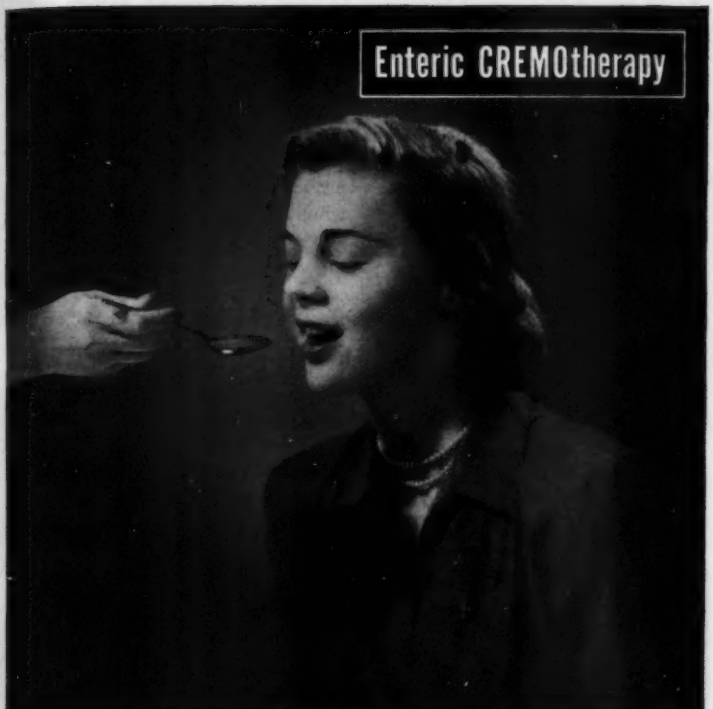
**Adults:** 2 to 3 tablespoonfuls four times daily (total daily dose of *Sulfasuxidine:* 12 to 18 Gm.)

**Children:** 1 to 2 tablespoonfuls four times daily (total daily dose of *Sulfasuxidine:* 6 to 12 Gm.)

**Infants:** 2 to 3 teaspoonfuls four times daily (total daily dose of *Sulfasuxidine:* 3 to 5 Gm.)

**Sharp & Dohme, Philadelphia 1, Pa.**

Cremosuxidine solves the problem of infant medication—may be given in the regular bottle feeding; any quantity *up to 50 per cent of the total volume administered* may be added to milk or formula and still pass through an ordinary rubber nipple.




Cremosuxidine is pleasant to take. Its smoothness and its mild chocolate-mint flavor make it attractive —even to squeamish patients who have gastrointestinal "upsets."

# Cremosuxidine

**Suspension Sulfasuxidine® with Pectin and Kaolin**

Checks diarrhea—helps to produce stools of normal consistency, practically without odor.

Inactivates toxins, adsorbs irritants, and facilitates their removal.

Combats infectious invaders, reduces bacteria count and encourages favorable change in intestinal flora.

edge pants, fairly tantalizing beneath filmy plastic drawers.

"Why, it's our Dr. Gundelfinger!" we hear the ladies whisper breathlessly. "My dear, have you noticed his *gams*?"

As he reaches his destination, however, a problem of etiquette arises. In simple courtesy, of course, he shucks his rubbers and takes off his hat, perhaps sheathed in its own gossamer rainskin. But as a matter of propriety, what more should he remove? Dare he even open his coat and reveal those black-bordered guard tops, those provocative trouser clips? Mightn't the patient engage him in a long discussion, of her own garter-belt problems?

Alas, the answers evade us. To be sure, the doctor could leap lightly upon a chair and, having previously slipped his hands unnoticed under his coat to unsnap the clips, be rid of his guards with a deft shake of each gam—possibly to the accompaniment of some such pleasantry as "Never mind the drops—just rain, you know." Yet this leaves wholly unsolved the matter of later getting them on again in an equally dignified and professional manner.

No, as we see it, they are a garment to be donned and doffed in the privacy of one's boudoir. The raincoat should be worn with them constantly, buttoned up. This may prove a bit warm, indoors. But surely this is a minor inconvenience in return for glorious freedom henceforward from rain, mud, and, above all, creaselessness.

*".....THE SO-CALLED TOXEMIAS OF PREGNANCY ARE IN REALITY NUTRITIONAL DEFICIENCY STATES."*[1]

By safeguarding the expectant mother against nutritional deficiencies, clinical investigators have markedly reduced or prevented toxemias of pregnancy, stillbirths and impaired development or dysfunction of the newborn.[2, 3, 4, 5] An adequate supply of essential vitamins and minerals is now recognized as an integral part of *every OB regimen.*

OBRON, specifically designed for the OB patient, has proved to be both a dependable and efficient dietary supplement.

By providing balanced proportions of 8 vitamins and the essential minerals —calcium, phosphorous and iron, OBRON helps protect against the "so-called toxemias of pregnancy" and promotes optimal well-being of both mother and fetus.

1. Spies, T. D.: The 1948 Year Book of Endocrinology, Metabolism and Nutrition, Genitourinary System, p. 393.
2. Burke, B. S.: Obst. & Gynec. Survey, October 1948, pp. 716-718.
3. Warkany, J.: Obst. & Gynec. Survey, October 1948, p. 693.
4. Allen, E. D.: Chicago Med. Soc. Bull., (April 8th) 1950, p. 834.
5. Burke, B. S.: Obst. & Gynec. Survey, October 1948, pp. 719-720.

EACH CAPSULE CONTAINS

| | |
|---|---|
| Dicalcium Phosphate Anhydrous* | 768 mg. |
| Ferrous Sulfate U.S.P. | 64.8 mg. |
| Vitamin A | 5,000 U.S.P. Units |
| Vitamin D | 400 U.S.P. Units |
| Thiamine Hydrochloride | 2 mg. |
| Riboflavin | 2 mg. |
| Pyridoxine Hydrochloride | 0.5 mg. |
| Ascorbic Acid | 37.5 mg. |
| Niacinamide | 20.0 mg. |
| Calcium Pantothenate | 3.0 mg. |
| Cobalt | 0.033 mg. |
| Copper | 0.33 mg. |
| Iodine | 0.05 mg. |
| Manganese | 0.33 mg. |
| Magnesium | 1.0 mg. |
| Molybdenum | 0.07 mg. |
| Potassium | 1.7 mg. |
| Zinc | 0.4 mg. |

*Equivalent to 15 gr. Dicalcium Phosphate Dihydrate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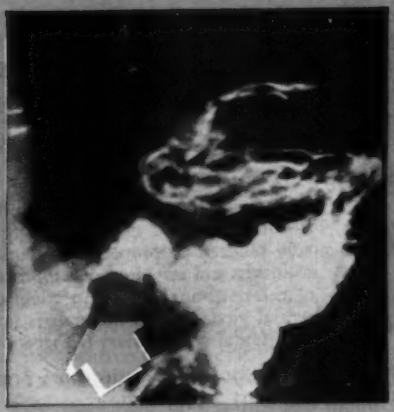
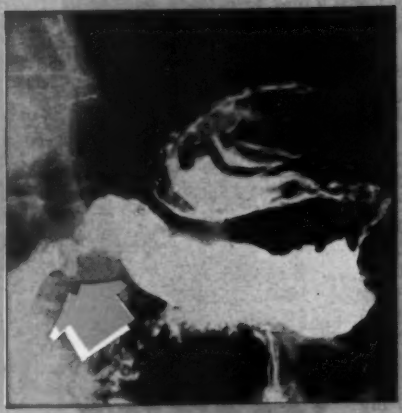


**Before Banthine**



**At 23 Days**

**At 118 Days**

RESEARCH IN

# Banthīne*

**BROMIDE**

**Brand of Methantheline Bromide**

—the neurogenic approach to peptic ulcer therapy—is a true anticholinergic agent.

Through its inhibitory action on the nervous mechanism, Banthīne reduces the vagotonia characteristic of peptic ulcer patients—the result is a consistent decrease in hypermotility and, in most instances, hyperacidity.

**SUGGESTED DOSAGE:**

One or two tablets (50 or 100 mg.) every six hours.

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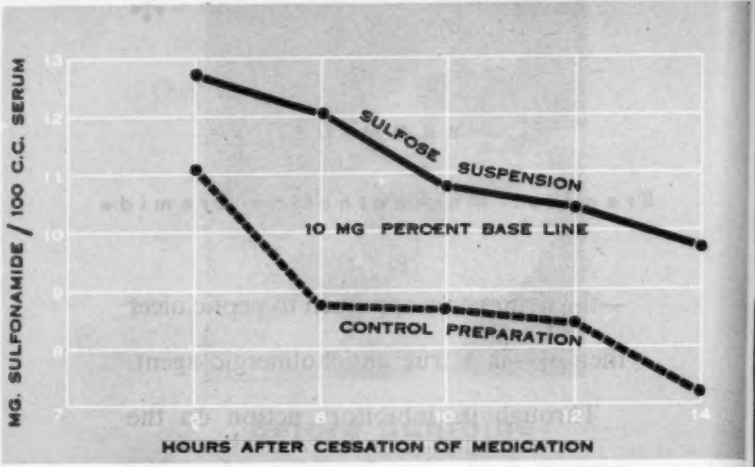
*Important Therapeutic Advantages*

## HIGHER, MORE PROLONGED BLOOD SULFONAMIDE LEVELS




Clinical comparison of blood sulfonamide levels after discontinuance of medication (Dosage, 40 cc. initially, then 10 cc. q. 6 h. for total of 24 hours). SULFOSE and the control preparation have the same sulfonamide composition.

**It is not enough** for a sulfonamide to be so soluble that the likelihood of urinary concretions is minimized. Triple sulfonamide therapy, as provided in SULFOSE, assures such solubility.

The important feature for therapeusis is the achievement of high, sustained plasma sulfonamide levels.

Clinical findings prove that Suspension SULFOSE, prepared with a unique suspending agent, produces exceptionally high and prolonged blood sulfonamide concentrations.

SUPPLIED in bottles of 1 pint.

Also available: convenient-to-use Tablets SULFOSE.

*Each tablet is equivalent in sulfonamide content to one teaspoonful Suspension (0.166 Gm. each of sulfadiazine, sulfamerazine, and sulfamethazine).*

Wyeth®

# SULFOSE®

TRIPLE SULFONAMIDES WYETH

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# HELPING YOUR GERIATRIC PATIENTS COMBAT BILIARY DYSPEPSIA AND CONSTIPATION

The high incidence of biliary tract disorders* focuses attention on the hepato-biliary system when patients past age 40 complain of gastrointestinal discomfort, flatulence, and constipation. Caroid and Bile Salts Tablets assure effective relief of retarded intestinal function in aging patients by—

1. *stimulating bile flow*
2. *improving digestion and absorption of foods*
3. *gentle laxation without whipping the bowel*

—thereby aiding reestablishment of peristaltic function

**DOSAGE:** 1 or 2 tablets after breakfast and at bedtime with a glass of water.

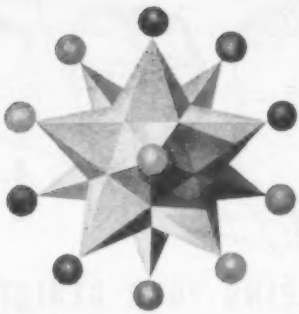
*Samples available on request*

**AMERICAN FERMENT COMPANY, INC.**
1450 Broadway, New York 18, N. Y.

*Rehfuss, M. E.: Penna. Med. J. 42:1335, 1939

**CAROID AND BILE SALTS** *tablets*

*Specifically indicated in* biliary dyspepsia and constipation



# CARBO-RESIN

(SODIUM REMOVING RESINS, LILLY)

## *begins a new era of edema control*

Ordinary table salt, so necessary to the acceptability of food, may now be permitted more liberally to patients with acute congestive heart failure and to others whose retention of sodium is excessive.

The two cation exchange resins in 'Carbo-Resin' capture and effectively remove undesired sodium. One of them also prevents the depletion of potassium by making a supply available for absorption. An additional ingredient, a special anion exchange resin, helps the other resins to remove more sodium. Moreover, it is especially important because it lessens the hazard of acidosis that may occur when cation resins are used alone.

Edema may be controlled by 'Carbo-Resin' with only moderate restriction of sodium. This new regimen makes it possible for injections of diuretics to be given less frequently or often eliminated. In those cases in which mercurials are contraindicated, 'Carbo-Resin' can provide an alternate treatment.

Details on dosage and other important information on 'Carbo-Resin' may be obtained from your Lilly medical service representative or by writing to

*Lilly*

ELI LILLY AND COMPANY INDIANAPOLIS 6, INDIANA, U.S.A.

# Editorial

## Too Many Meetings

● If you've ever stopped to count up the number of medical meetings you're expected to attend these days, you know why more and more doctors are muttering:

It's time to call a halt!

In one city we visited recently, the average hospital has from fifteen to twenty staff conferences a month, most of them compulsory. Add to these the other medical meetings a doctor may feel obliged to attend—county societies, specialty societies, an occasional state or national group. The total makes you wonder how *any* M.D. has enough time left for seeing patients.

Granted, such meetings are a vital part of our continuing education. But it's scarcely debatable that they'd become *more* so if we had fewer and *better* meetings.

Hospitals have been notable offenders in pushing the trend the wrong way. "When you're an interne or resident," one doctor told us, "you expect to sign attendance sheets at staff meetings almost every day. But when this requirement is imposed on attending staff members as well, it begins to conflict with our other responsibilities. And when, instead of the one full-scale meeting a month required by the American College of Surgeons, the total is jacked up to four, eight, or twelve—well, it's time we did something about it."

That's exactly what's happening right now in Detroit. "To get the ball rolling," says Dr. Arch Walls, a leader in this movement, "requires action by the largest organization of doctors in the area."

So the Wayne County Medical Society (2,200 members) decided recently to set the pace: It cut down its own meetings to one a month (from four just a few years ago).

Having set the example, these doctors are now seeing that others follow it up. To coordinate the area's chaotic schedule of medical meetings, they're organizing a city-wide committee—including hospital administrators and chiefs of staff.

"We're convinced," says Dr. Walls, "that time-wasting duplication of speakers and subjects can be eliminated—and that the total number of meetings can be reduced by at least 50 per cent."

A goal worth shooting for? Try counting up the medical meetings in your own community and see if you don't agree:

It's time to call a halt!

—H. SHERIDAN BAKETEL, M.D.

# The Doctor Takes a Farm

***. . . and heigh-ho the derry-o, he nearly loses his shirt. Before you obey that idyllic impulse, read this***

● A New York gynecologist—we'll call him George L. Gormley—had $60,000 in spare cash and a hankering for cow barns and clover. What could be sweeter, he often wondered, than a stretch of green acres earning a tidy investment income—and providing week-end sanctuary as well?

Searching the hinterlands west of the Hudson one day, he found his dream spot—a picturesque, 85-acre farm tucked away in the foothills of the Ramapos. The house had a breath-taking view across the valley; and a litter of setter pups went with the place. Before night-fall, the doctor had closed the deal and become a gentleman farmer.

Once the first flush of enthusiasm had worn off, it occurred to him that he ought to get some expert advice on running the place. The following Saturday a Mr. Hawkins, representing a farm management firm in the city, rode out with him to look the situation over.

Their inspection tour may have missed a few individual blades of grass, but not much else. When it was over, Dr. G. figured he'd covered more ground on foot than at any time since a two-week hiking trip he'd once taken as a second-class Boy Scout. Furthermore, the Hawkins prognosis was grim.

"I'd sell it," he remarked, as they drove back to town.

"*Sell?* I just *bought*."

"Well, you might be able to make a dairy operation go, by adding another fifty acres. But you'd be smarter to sell."

The farm, he explained, was "out of balance." Twenty acres were in woods and wasteland, another ten were occupied by roads and buildings. Of the remaining fifty-five, fifteen were low meadow—too rough to be worked without expensive drainage.

There wasn't enough land for a sizable herd, yet the barn was built for seventy cattle. That meant its upkeep would be too high for the number of cows that could be pastured. [*Turn page*]

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***By Arnold P. Johnson***

*The author is a member of the firm of Burlingame, Field, Pierce & Browne, farm management consultants.*

"You might try truck or poultry," Hawkins added, "but it isn't really right for those, either."

"What about beef cattle?"

Hawkins smiled, the first time all day. "On that place? Suicide!"

The firm's report, over Hawkins' signature, arrived the next week. In addition to the barn/pasture dilemma, it now developed that 50 per cent of the topsoil was gone—eroded away. What was left was highly acid. The report went into the cost of remedying these deficiencies, wound up with the conclusion that it wasn't worth it.

The doctor got Hawkins on the phone.

"You told me what was wrong," he said, "but you didn't tell me what to do."

"I told you that the other day."

"But I want a farm. I want a place to relax."

He could have sworn he heard the man chuckle.

"Next time," Hawkins advised him, "get in touch with us *before* you buy."

After three weeks of soul-searching, George Gormley sold the place to a bright-eyed insurance man from Patrson, N.J. Then he called Hawkins back.

"I lost $2,400," he reported, "and the new owner is strictly a cat man. Need any setter pups?"

"No," said Hawkins, "and I think you got off lucky."

"I still want a farm. How about helping me scout a few next weekend? Be a nice outing for you."

The Hawkins fee for nice outings, he said, was $75 a day. The doctor mentally divided this into $2,400 and decided that Mr. Hawkins' company would be a bargain.

### *Where to Look*

Came the week-end, and they headed somewhat farther afield than Dr. Gormley had previously ranged. Out in Sussex County, some fifty miles from the city, Hawkins said, the hunting would be better—better land, better values. At that, it would probably take them several trips to find anything. His firm had had about $1 million in client funds to spend on farms since the war, he said; but for lack of right-priced buys, it had spent only about a third of the money.

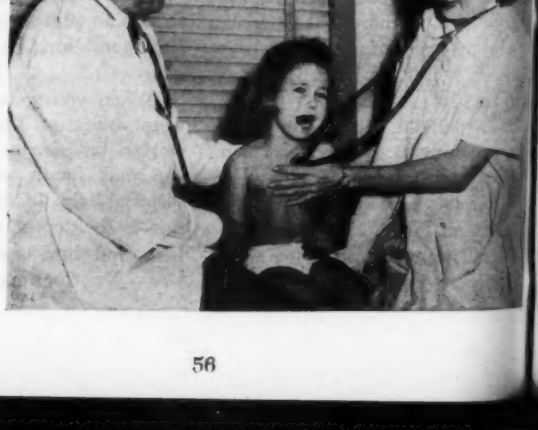
"Another reason for getting farther from the city," he went on, "is that labor will be cheaper—probably $150 to $200 a month, plus the usual perquisites. Where you compete with industry it will run you 25 per cent more."

The doctor, swinging his car around an oil truck, whistled softly. "Inflation! Now, back when I was a boy . . . "

"When you were a boy, things were different. The hired help worked for peanuts. And the average small, family farm needed only seasonal help. Its diversified activities—a few cows, some chickens, hogs, and three or four crops—were

[*Continued on page* 147]

For a quick getaway on house calls, this married medical pair finds that two cars are a must. But they often work side by side in the treatment room. They're fellow officers, too, in the Louisiana Academy of General Practice: Dr. Janie Topp is secretary, Dr. O. W. Topp is a director.



# When Doctor Marries Doctor

***Life is apt to be hectic, but most medical mates wouldn't have it otherwise***

• One doctor in the house is enough to keep most families well frazzled. What happens when *two* M.D.'s set up housekeeping and practice together?

To run-of-the-day domestic crises is then added a double dose of professional tensions. The result is quite likely to take the form of experiences like the one reported recently by Drs. Norman and Maria Baker of Fergus Falls, Minn.:

From suppertime on, this particular night, their home telephone jangled constantly with urgent calls for "Dr. Baker." Both doctors went out several times during the evening. By chance, their comings and goings dovetailed, so that neither realized the other was answering calls too. In the morning, Dr. Norman asked dazedly: "Who was out last night—you or me?"

Dr. Maria shared his confusion. It turned out that each had visited several of the other's patients by mistake. To top it all, two puzzled patients had had separate visits from *both* the Drs. Baker.

With same-name doctors under one roof, such mix-ups are apt to be chronic. But though they're hard on the physicians, they're often easy on the patients—especially in a crisis.

Take the case of the young man who hurried not long ago into the office of Dr. William Berenson in Lynn, Mass. He had a girl in tow who complained of "bellyache." She had one, all right; she was in labor. Dr. William, though, was away for the day.

Fortunately, the doctor had a wife. Dr. Hilda Lang Berenson bundled the couple off to the hospital and delivered a strapping boy.

Professional disagreements flare up, of course, in the best-regulated medical marriages ("We never see eye to eye in treating obesity," reports one couple). But the commonest problems appear to be: (1) the difficulty of "raising children from the office," as one couple puts it, and (2) the "lack of free time together."

Offspring of doctor parents learn independence early. They have to. The stock paradox in many a double-M.D. family is the pediatrician mother whose own youngsters are

***By James Fuller***

orphans of the storm of appointments.

Consider the history of one such couple in Chicago. Told by physicians that she couldn't bear children, the wife refused to accept the verdict. She studied for an M.D. in the hope of discovering a happier out. Her first child was born during her junior year at medical school. Four others followed. Today with five good reasons for staying home, she has to devote so much time to her pediatrics practice that most of her private mothering is done by remote control.

Medical mates may be pillars of strength to their patients, but they're often just typical parents at home. Drs. Charlotte and Claus Jordan of Stroudsburg, Pa., tell of their sudden helplessness when their 2-year-old son came down with the croup. As they stood wringing their hands at his bedside, Dr. Charlotte's mother said testily: "Well, for heavens sake! Why doesn't somebody call a *doctor*?"

The penalty of seeing each other only as doctors who pass in the night is greatest, of course, for those medical couples who practice in separate offices.

For the Drs. Topp of Lake Charles, La., this frustration has been partly avoided by joint practice in their own Topp Clinic. As fellow G.P.'s, Janie Topp and O. W. Topp are often together at work, if not at home.

Their pattern of professional and domestic life doesn't solve the unsolvable, but it's a tolerable and lively compromise. The Topp day begins before 7 A.M.—unless one of them has had a delivery in the small hours. They eat breakfast together, then spend some time with the children (an adopted boy and girl, to whom a *bona fide* Topp sibling is about to be added).

Most mornings, the Topps go their separate ways on house and hospital calls until shortly before noon, when each arrives breathlessly at the clinic. ("Is Dr. Janie here yet?" "Is Dr. O. W. in yet?") Then office cases keep them collaborating until late afternoon. When office hours end, Dr. Janie goes out one door of the clinic to her car, Dr. O. W. through another door to *his* car—both to make more calls. Once in a while, patients permitting, they have dinner at the same time.

Thus the Topps are able to keep in closer touch than many other medical couples. In surgery, says a friend, "they're less like two doctors than like one with four hands."

Spur-of-the moment cooperation has become a kind of Topp legend. In their early days in Lake Charles, Dr. O. W. was still in the Army. Dr. Janie set up her first practice in a front-bedroom office. Asleep one afternoon, after a tour of duty on the post, Dr. O. W. was waked by a screaming patient. Tiptoeing to the office door, he saw his wife and a frantic mother fighting to hold a struggling boy. Quickly slipping on

a bathrobe, Dr. O. W. strode into the room, incised an abcess in the boy's ankle, then went wordlessly back to bed. Said the dumbfounded mother afterwards: "Who on earth was *that*?"

Another time, Dr. O. W. and his nurse were engaged in a battle with a small, teeth-clenched youngster who didn't want his throat examined. Suddenly Dr. Janie walked in. Sensing a new foe, the boy reacted with a tonsil-revealing roar. Dr. Janie leaped for a tongue depressor, and the battle was won.

What do patients think of this two-in-one team? Apparently they fancy it—except perhaps for the occasional person who can't decide which Topp to take. One woman changed her mind three times while waiting in their reception room. But another said: "Me, I never did like taking just one doctor's opinion Having the Topps is like double indemnity."

Now that Dr. Janie is enceinte, her husband has taken over most of her night calls—another liability of the male M.D. who marries a doctor. At his request, though, the hospital has provided a high chair for Dr. Janie's use at the operating table. Says Dr. O. W.: "Pregnant or not, she's the best assistant I've ever had."

Other couples have other ways of living and working together. Faced with the daily puzzle of medical mates—how to enjoy each other's company under the stress of constant shop talk—Drs. Hugh and Hedwig Kuhn of Hammond, Ind., worked out a different solution. "Early in the game," they explain, "we decided to work hard at home base. When we got ready to play, we'd simply go a long way off."

They've been as good as their word—even though the Kuhn idea of play resembles a postman's holiday. Not long ago, for example, they spent four months in Africa. They worked in one mission hospital in Northern Nigeria, in another hospital in the jungles to the south. They lectured at a medical school in South Africa, returned by way of England, where they lectured some more. Before next January they plan to take similar trips to Mexico and Portugal.

In Hammond, the Kuhns run an OALR clinic with a staff of sixty-five. Dr. Hugh's specialty is eye surgery; Dr. Hedwig concentrates on industrial ophthalmology. To take up any extra-curricular slack, they run a farm and do civic and medical organization work. In between, they have raised two sons to be doctors.

Like other medical couples, the Kuhns had their share of "boss trouble" in the beginning, twenty-eight years ago. They settled it, too, once and for all. Says Dr. Hedwig: "There can be only one boss in this kind of set-up. And the boss in this family is my husband. I wouldn't want it any other way."

Maybe these married M.D.'s have something after all! END

Do We Need

# A Federal Medical Academy?

Less than a month after Korea, two proposals for a "United States Medical Academy" were docketed in the House of Representatives. Although neither bill gained much headway during the 81st Congress, the idea is far from dead. Since May, when one of the proposals was reintroduced, doctors have begun to show rising interest in the scheme.

To help crystallize thinking, here is the case for and against a "West Point of Medicine." Supporting the idea is Representative Louis B. Heller (D., N.Y.), its chief sponsor in the current Congress. Writing against the proposal is Representative A. L. Miller (R., Neb.), one of the M.D.-members of the House.

## YES *says Congressman Heller*

● Twice running, our nation has come up against a grave emergency with doctors in short supply. What's needed seems almost certainly to be a new source of M.D.'s.

Ideally, any fresh source of supply should provide a steady flow of physicians for the armed services, for Government health agencies, and (under extraordinary conditions) for civilian requirements. A Federally supported medical academy would, I believe, meet all these needs.

## NO *says Congressman Miller*

● America's medical schools produce the bulk of the world's best doctors. Within our existing framework, and without turning to an untried system, we have the means of producing enough well-trained physicians for all our needs.

Why, then, set up a Federal medical academy?

Supporters of such an academy favor it chiefly as a means of relieving the "doctor shortage." And this "shortage," they claim—because of the country's emergency statu-

Had a ready reservoir of doctors been available in June 1950, the confused scramble for medical men we have witnessed during the past year might have been averted. We would have had, instead, a firm nucleus upon which to expand our military medical forces without disrupting the civilian economy.

As things stand, there are huge gaps all along the line—and little hope of respite. Priority I has claimed 10,000 young doctors; by fall, nearly all of them not deferred will be in uniform. This year's graduating class will scarcely make up the deficit.

Clearly, the pinch will not be temporary. By 1954, Dr. Howard Rusk warns, there will be a shortage of 22,000 physicians. For the moment, we must rely on the doctor draft. But what about later on—the next decade, and the one after that?

The answer, I believe, may be found in a Federal medical academy. Here are some of the specific proposals contained in H.R. 3931, which I introduced in Congress on May 2:

¶ Students would be appointed in a manner similar to that used by the military academies. Age limits: 20 to 25.

¶ Admission requirements would

has become essentially a Federal problem.

Actually, when there are not enough physicians for our armed forces, there are also not enough doctors for the home front. So the problem is a lot broader than has been admitted.

We are told that the Korean mobilization points up the desperate need for doctors. The facts of the Korean mobilization are these:

In June 1950, the Army called for 2,167 physicians. Just recently another 1,200 were called. Perhaps 2,800 more will be needed as recruitment for the armed forces progresses.

Thus, under present circumstances, the military forces will have taken 6,167 physicians by next fall. If the draining off of this comparatively small number of M.D.'s will create a desperate need and will leave us without enough medical care for civilians, then it's passing strange that we were able to spare 60,000 physicians during World War II.

A Federal medical academy, it's claimed, can be operated outside bureaucratic and military influences. But I have yet to be convinced. The late, unlamented red-tape days (*circa* 1941-46) proved that military science cannot be compared

**YES** include a college or university degree (or sufficient entrance qualifications to meet the standards of the student's home-state medical school).

¶ Courses would consist of those prescribed by the A.M.A.

¶ Students, upon graduation, would be commissioned in any branch of the armed services, in the Public Health Service, or in any other Federal service for five years.

Not only would such an academy create a reserve pool of military M.D.'s. It would also offer specialized training which, except in rare instances, medical students do not now get.

Specialization is as important today in Federal services as elsewhere. We need more men specifically trained in aviation medicine. We need more men who know the medical factors of life in underseas craft. We need more authorities on the physiological aspects of service in tropical and polar regions.

And consider our woeful lack of specialists in the Public Health Service, both at home and abroad. Existing medical schools simply don't turn out enough public health men to meet minimum needs. A Federal medical academy would help fill all these gaps.

Furthermore, specialists in military and government medicine would attain, through such a medical academy, the full professional status they deserve.

Obvious precedents for this idea are the two U.S. military academies,

## Do We Need a Federal Medical Academy? *(Cont.)*

**NO** with medical science. For further proof, consider the Government-administered system of military medical education in France.

One Washington doctor, an authority on the system, describes it this way: "The emphasis is placed on degrees and advanced studies, at a sacrifice of practical experience. Doctors attain medical stature and rank almost automatically on completion of a certain type of course. To my mind, there is an excess of theory; sometimes French medical officers spend up to fifteen years taking one course after another."

Which raises a pertinent question: Would a theorist of fifteen years' standing help alleviate a doctor shortage?

Obviously, the development of the individual student gets scant attention under such a system. In this country, fortunately, the medical curriculum focuses on individual needs. And that's the way it should be.

Our present medical schools stress the all-importance of the doctor-patient relationship. Would this concept survive the academy system? My guess is that it would be

which produce some of the finest Army and Navy officers in the world. Applied to the study of medicine, why shouldn't the same idea produce some of the finest doctors in the world?

Critics of the academy plan say it would dilute the quality of medical education. Military rigidity, it is charged, would hamper professional freedom.

I must emphasize, therefore, that the proposed medical academy would have *students*, not cadets. Teaching would be in the hands of fully experienced civilian and military professors. The curriculum would include all courses now prescribed in civilian medical colleges.

A Federal medical academy would keep us better prepared for national emergencies and would, at the same time, help to broaden the scope of medicine in this country. Specialists could be trained for many research fields not now fully exploited. Veterans' care and civil defense would be aided. We could have new assurance that no region of our country would be without a sufficient number of doctors at any time for any reason.

The idea of Federal responsibility in these matters is gaining wide acceptance. It falls logically upon the shoulders of Government to train personnel for its own purposes. No one questions the Government's responsibility to train Army and Navy field and staff officers. So why shouldn't the Government educate and train its *medical* officers? END

supplanted by emphasis on the relationship between subordinate and superior.

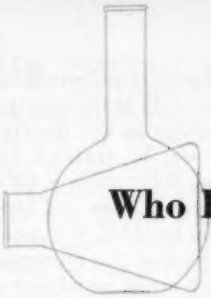
Recently I asked a top-level Government doctor what he thought would happen in a Federal medical academy. His verdict was that "The therapeutic trial-and-error method would suffer; the scientific approach would be displaced by the 'Yes, Sir' approach. We've got complete freedom in medical education, and we want to keep it that way."

It is interesting to note, in passing, that the armed services recently turned to civilian consultants for guidance in their residency training programs. Only since this has happened have standards in military hospitals approached those in civilian hospitals.

And how about mechanics of the academy scheme? Signs are that its sponsors are not entirely familiar with medical education machinery.

For one thing, the type of academy they foresee would be several times the size of our largest existing medical school. Ten years might well be needed to establish its fa-

[*Continued on page* 161]



# Who Pays for Medical Research?

● Research has made the difference between the medicine you learned in school and the medicine you practice today. More than half the drugs you now prescribe, for example, were unknown ten years ago.

In the next decade, you can expect even more rapid changes, because medical research in the U.S. is now rolling at the fastest pace in history. More than $181 million cash will be spent directly on it this year alone. That's ten minutes the figure of 1941. It means that for you—and for each one of your colleagues—somebody is now spending almost $1,000 a year to make your services more productive.

Of course, you're shouldering part of the bill—in the taxes you pay, in the gifts you make to voluntary health agencies. But John Q. Public is multiplying your dollars. From every source, there's more money in sight for medical research than ever before.

This outlook stems from a new and original study just completed for MEDICAL ECONOMICS. Here are the hitherto unpublished figures on where these medical research dollars come from (as of 1951):

| Source | Amount (Millions) | Percent of Total |
|---|---|---|
| Government | $76 | 42% |
| Industry | 60 | 33 |
| Philanthropy | 25 | 14 |
| Hospitals, medical schools | 20 | 11 |

The grand total of $181 million represents only the direct cash outlay for medical research operations. Indirect expenditures, cash equivalents in service, and construction costs add up to many more millions; but it's practically impossible to account for them.

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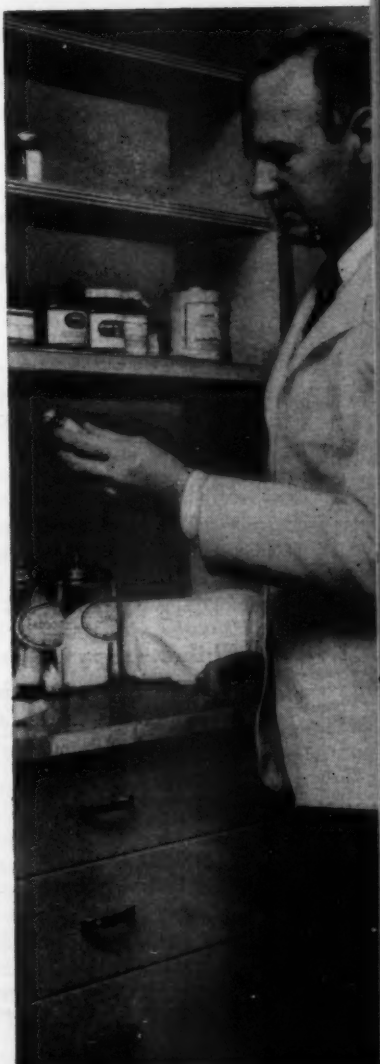
*The author is an experienced writer and researcher in the health field. A former faculty member at Columbia University, he has also served as managing editor of three different medical journals. His articles have appeared in such magazines as Look, Scientific Monthly, and*

***More than $181 million is being laid out annually by government, industry, philanthropy. Here's what this means to physicians***



Ever since World War II, people have been predicting that Uncle Sam would eventually become the largest direct contributor to medical research. Just this year, the prophecy came true.

Yet until the 1940's, Federal expenditures for medical research were almost negligible—less than $1 million a year. The tide turned between 1941 and 1944, when $15 million in U.S. funds helped produce penicillin, blood plasma, antimalarial drugs, and a host of other medical advances.

The Public Health Service, which did most to turn the tide, remains the biggest paymaster of Federal research funds. Its grants-in-aid to medical schools, hospitals, and others have been rising steadily. In 1950, it thus disbursed $11.6 million; in 1951, for such aid, it expects to pay out $20.7 million—to

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*By Justus J. Schifferes, Ph.D. Today's Health. He has written five books and he was also co-editor, with Dr. F. R. Moulton, of "The Autobiography of Science."*

## Sources of Medical Research Funds

| | Direct Cash Outlays In 1951 (Millions of Dollars) |
|---|---|
| **Government** | |
| Public Health Service | 35.2 |
| Atomic Energy Commission | 18.0 |
| Department of Defense | |
| Army | 6.8 |
| Navy | 6.0 |
| Air Force | 4.7 |
| Veterans Administration | 4.5 |
| Other (*e.g.*, Children's Bureau) | 1.0 |
| | 76.2 |
| **Industry** | |
| Pharmaceutical and proprietary | 52.5 |
| Industrial foundations | 5.0 |
| Other | 2.5 |
| | 60.0 |
| **Philanthropy** | |
| Philanthropic foundations | 10.0 |
| Voluntary health associations | 10.0 |
| Personal donations | 5.0 |
| | 25.0 |
| **Profession*** | |
| Hospitals | 15.0 |
| Medical schools | 5.0 |
| | 20.0 |
| **Grand total** | **181.2** |

*Exclusive of free-service contributions of physicians.

say nothing of its other medical research expenditures.

Other Government agencies are spending more for medical research, too—notably the Atomic Energy Commission. How much the new National Science Foundation will pour into the pot cannot yet be predicted; it has only begun to operate.

Industry's support of medical research is climbing apace, though not at so rapid a rate as that of the Government. Most of industry's $60 million a year comes from pharmaceutical companies.

Helping to boost this total still higher is the prospect of stiffer corporate taxes. Research is a deductible business expense, and most firms would rather spend money that way than hand it to Uncle Sam.

The philanthropic foundations, which pioneered the financing of medical research in the United States, are likewise paying out more than ever (even though their contribution, in proportion to the total, is much smaller than in years past).

There are more foundations now, and they have more money. The Commonwealth Fund, for example, has added $20 million to its assets during 1951 alone; the Ford Foundation has begun to spend its huge capital fund of $200 million.

Nor has philanthropy lost its pioneering spirit. Says Dr. Willard Rappleye, president of the Josiah Macy Jr. Foundation: "In every period of scientific development, certain areas of research are in fashion, while others are unpopular. A foundation has a responsibility to seek these neglected, significant areas of research. The [Macy] foundation's support of hypnosis is a case in point."

So if your research idea is off the beaten track, you still have a good chance to win financial support—thanks in large part to the foundations' willingness to take a flyer.

### *Health Agencies Active*

Every time you give money to a voluntary health agency or lend your name to its letterhead or serve on its board, you're helping collect funds for medical research. Practically all such agencies support some sort of research program—though the percentage of funds ear-marked for research varies widely.

The newer agencies try to channel at least 25 per cent of their collections into research. However, patient care and public education absorb most of their cash. Nearly all agencies end up by needling more research money out of the Government.

Campaign collections by voluntary health agencies are climbing steadily. Last year the National Association for Infantile Paralysis took in $26 million; the National Tuberculosis Association, $20 million; the American Cancer Society, $15 million.

Those are the three big boys. But

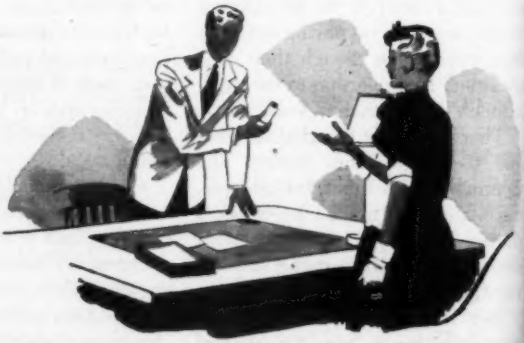
[*Continued on page* 139]

# Eight Ways to Invite a Malpractice Suit

## Fail to consult in doubtful cases

"No, we don't need to call in another doctor. Her case is just a bit more stubborn than most."

## Rely on verbal instructions



"Be sure to dilute it with an equal part of water when you apply it."

**Leave town without providing a substitute**

**"No, I didn't bother getting anyone to 'cover' for me. My patients can get along without me for a few days."**

**Be careless about supervising office help**

**"About Mrs. Kay's injection. I guess you can give it. You've seen me do it often enough."**

TURN PAGE

## Perform an unauthorized second operation

"Now that her septum is taken care of, perhaps I'd better remove those infected tonsils."

## Neglect to X-ray where bone injury is possible

"It's only a sprain. We won't need an X-ray."

**Demand payment while there's any question of maltreatment**

**". . . so unless I hear from you within ten days, I'll be forced to turn your bill over to my lawyer."**

**Neglect to get written consent from both husband and wife when operation may cause sterility**

**"Well, as long as your husband has no objection, we'll go ahead with the operation."**

END

# Business Services to Your Order

***They must be tailored to fit each physician, says this professional management man***

● Though the woods are full of plain and fancy collection agencies for doctors, there are only a dozen or so professional management counselors offering a fully-rounded array of services. That's why I was looking forward to my talk with J. Paul Revenaugh, reputed to be among the top twelve.

The lettering on his door, twenty-one floors above street level, read, "Service Bureau of Chicago." Walking in, I found myself in what might well have been the reception room of an up-to-date physician's suite.

I'd hardly settled down on the ultra-modern settee when the receptionist opened her sliding glass panel to announce that Mr. Revenaugh would see me at once. Here, I noted mentally, was an office from which more than one physician could take a cue.

The girl led me down a brief corridor, past a battery of assistants, and into a multi-windowed office with a wide view of Lake Michigan. A stocky, agreeable man got up to shake my hand, then o fered me a chair. I started the bi rolling by asking him how he g into the business of minding th doctor's business. He obliged by g ing back to the beginning.

"I got started by going to wo with a man named V. S. Loventha in Cleveland," he said. "That w over eighteen years ago. Loventh pioneered this business, just aft the first war. He began by sho dering the credit worries of fo Cleveland doctors whose accou receivable had been piling up o them. It was those four doct who really conceived the profe sional management idea."

"Didn't Loventhal first approa *them* with the idea?" I asked.

"No, they went to him as a m tual friend whose business abil they thought well of. (Parenthe cally, he'd picked up his training the liquor business.) The four do tors told him they wanted a cre manager—not just a collection age but a man who'd come into th offices and put things into su shape that another mountain of u paid bills wouldn't accumulate the future."

Gradually, this "credit manag

*By Alton S. Co*

expanded both his clientele and the scope of his services. Then he began taking on assistants. From this group have come some of the best-known professional management people today.

"Ernie Boggs, now of Detroit, was one," Revenaugh said. He tilted his head and squinted in recollection. "Another was Ray Swink, currently active in Cincinnati. There were more, too. Among them, they evolved most of the fundamental principles of professional management that still stand today."

To begin with, they found that doctors' bills were not going out with any degree of regularity. Sometimes an M.D. would delay for a year or more before rendering a statement. Monthly billing was a rarity. On the other hand, a few bills were being sent out before the patient was even out of the sickbed —an obvious source of annoyance.

"And from what I know of this particular area," Revenaugh said, "a surprising number of doctors are still making these same mistakes."

Early in the business, he went on, the Cleveland associates realized that the soundest approach was not merely to follow up patients, but also to develop proper business systems in the doctors' offices. So they set up cash receipt records and saw that the doctors' secretaries kept them up. They instituted monthly billing, regular as clockwork. They developed a progress chart, to show doctors how they were doing financially from month to month. (Tax advice was to come later, as income taxes grew stiffer and computation more complex.)

"Those of us who broke in at that time," said Revenaugh, "hit quickly on this still-basic maxim: The development of a practice depends not only on the medical results the doctor gets, but also on how well the patient understands those results and on how well he's satisfied with the way he is handled, as a human being, by the doctor and his aides."

"How long," I asked, "were you with the Cleveland men before you set up shop for yourself?"

"Only a couple of months. Remember, those were the blackest days of the depression, when a man who wanted to strike out for himself usually had to forgo the luxury of a lengthy apprenticeship. I'd been in the tire business, and Swink persuaded me to look into professional management. At first I thought he was nuts. But two months later I was hanging out my own shingle, here in Chicago—the week after forty local banks had closed. Fortunately, lean times are when doctors need professional management most.

"For the first ten years we followed the same pattern as Loventhal, Swink, *et al.* We tried to give every imaginable service to doctors —did everything but wipe noses— and charged a fairly high fee.

"But by 1943 most of our clients

were pretty well straightened out. They no longer needed the whole range of medical management helps. So we switched to a more limited form of service where we don't do any business procedures the doctor can just as well do himself. This has also helped us keep our fees down."

In his time, my host told me, he has hired doctors' aides, taught them good telephone technique, set up record systems, laid out new offices, helped doctors set fees, even developed personal investment and estate plans. He and his staff still stand ready to give any of their physician-clients guidance on such problems when needed.

"Satisfied patients are the secret of success in medicine," he says. "Our job is to help doctors satisfy patients from the first phone call until the last dime is paid."

His present basic service centers around a monthly operating statement that's made up for each client. "We don't do the doctor's bookkeeping for him; we see that his office staff takes care of that. But once a month we send a man in to pick off the monthly totals. The result is an operating statement that gives the doctor a complete picture of his finances, month by month.

"We ask that every penny received in his office be deposited in his bank, and that all expenditures be by check. Thus, everything shows up correctly on the monthly statement. Even when the doctor wants pocket money, he draws it by check."

"Can you actually get him to do that? Doesn't he find it a nuisance?"

"He'll seldom kick, once you've explained the whys and wherefores. You see, this way his personal expenses are accounted for, as well as his professional ones. That's important. A doctor can be earning a respectable income yet, if he doesn't know where it's going, he can still end up in the poorhouse.

"We also take care of our doctors' tax work," he added, "filling out their forms and even appearing for them in case of routine investigations."

Revenaugh has five trained men continuously making the rounds of doctors' offices to collect figures for the monthly operating statements. He or his partner, H. F. Keister, also calls on each client once a month. They stay from five minutes to two hours, answering questions that run the gamut. Some recent examples:

¶ A doctor's wife was expecting a baby; the doctor wanted advice on how to arrange his budget.

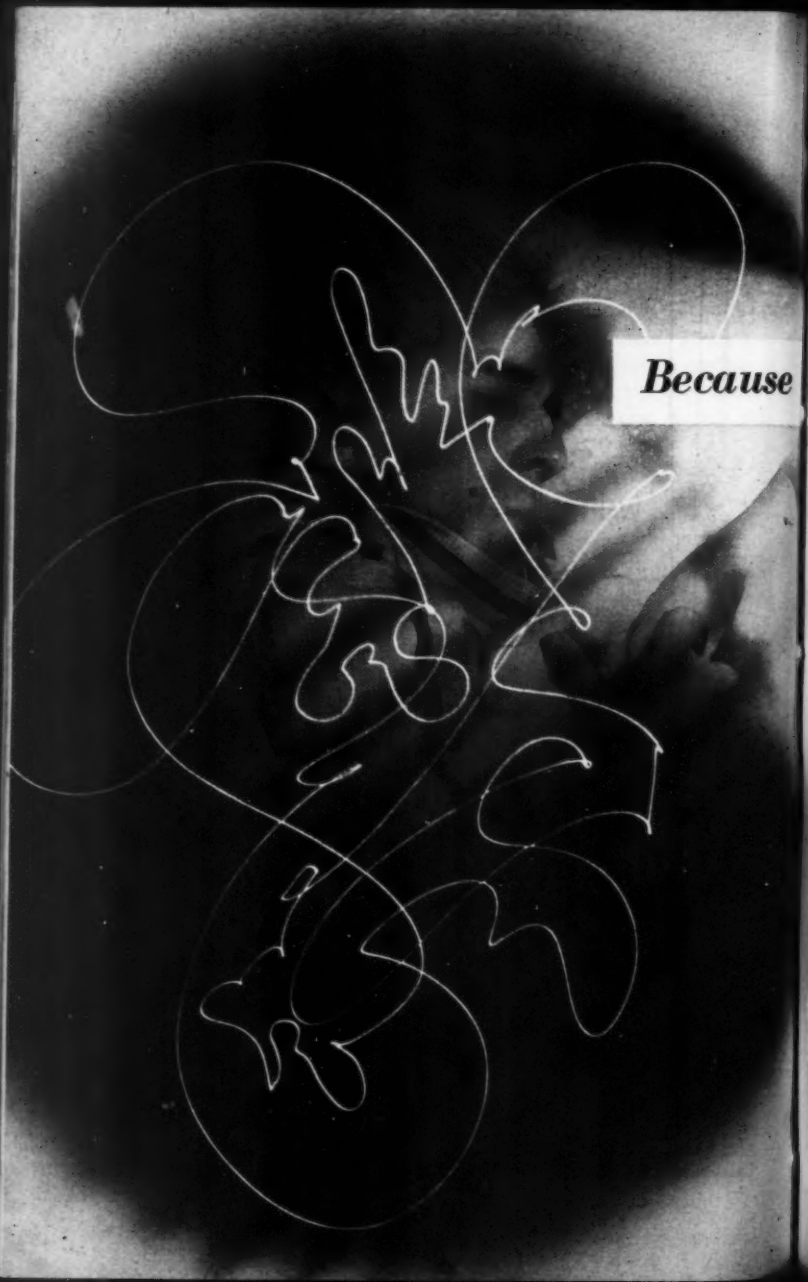
¶ Another thought the time was ripe to move into a new building; he wanted advice on the layout.

¶ A third needed help with his personal bill-paying procedure.

¶ One client thought his fee scale was outmoded; Revenaugh helped him make some changes.

¶ A doctor was having difficulty getting his aide to follow instruc-

## Are You a Sidewalk Superintendent?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*patients can't*

## "SLEEP OFF" *hypertension...*

*prolonged vasodilation should accompany sleep as well as the day's activities. (One more reason why NITRANITOL is the most universally prescribed drug in the management of hypertension.)*

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**When vasodilation alone is indicated.** *Nitranitol.* (½ gr. mannitol hexanitrate.)

**When sedation is desired.** *Nitranitol with Phenobarbital.* (½ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

**For extra protection against hazards of capillary fragility.** *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

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tions; Revenaugh offered suggestions.

¶ Another wanted to know whether he should charge for telephone consultations. Revenaugh's answer: No; there's no equitable way to set fees in such cases.

The partners also check such things as wills (making sure each client has one) and auto insurance (often advising a client to take out $100,000/$300,000 liability). These and other standard matters are broached during the monthly visits.

"How do you get doctors interested in your services to begin with?" I asked.

"For the past fifteen years," he replied, "our problem has been the other way around—deciding whom to accept as clients from among those who come to us. We couldn't possibly handle them all."

"How do you decide?"

"We try to judge how valuable to the doctor our service will be. We do a one-hour survey of the man and his office. If it looks as though we can help him, we take him on. But if we make suggestions and he continuously disregards them, we know we're wasting time and he's wasting money. In such cases, we simply quit."

I asked about the cost of all this. "Our fee," Revenaugh said, "is from twenty-five dollars a month up to several hundred, depending on how much service we give. In the case of some doctors, for example, we follow up delinquent accounts, sending letters on their letterheads signed by us as auditors (with a resulting collection percentage that's usually over 98 per cent). But not every client needs every one of these special services."

"Do most other professional management firms stick to an over-all pattern like yours?" I asked.

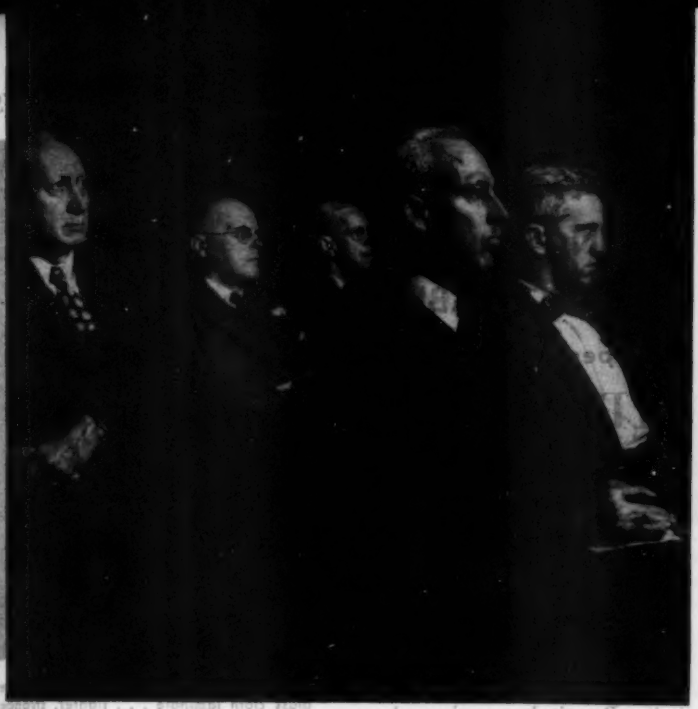
"No. They all have their own ideas. Some provide limited services to several hundred doctors. Others do the whole job for only a dozen or so.

"The one sure thing is that you can't render this service on an assembly-line basis. Each doctor and each problem is different. Many's the time I've had to sit in a doctor's waiting room for two or three hours, just watching how patients were handled, how the secretary conducted phone conversations, how the doctor instructed patients, etc."

"Why aren't there more good professional management people around the country?"

"Because," said Revenaugh thoughtfully, "it takes a unique combination of general business experience and specific insight into the doctor's problems. I'll tell you frankly, it took *me* about ten years to learn. Hundreds of other people have tried to start this service, only to give up in one to five years.

"The chief talent source is the young men now working as assistants to people really established in the field. That's why expansion is a slow business." END



# Let Medical Movies Help You Out

***What they offer you, where to get them, and how to use them to best advantage***

● What's holding up the wider use of medical films at the level of the Main Street M.D.? Three lacks, according to Ralph P. Creer, secretary of the AMA Committee on Medical Motion Pictures:

1. Lack of enough films, especially those slanted for the G.P.

2. Lack of knowledge, on the doctors' part, of good existing films.

3. Lack of appreciation of the motion picture's value in post-graduate education.

Surprising? Yes—considering that

***By James Fuller***

# NOW... LIGHTER, STRONGER, MORE COMFORTABLE

## *Orthopedic Structures of*

# FIBERGLAS

## *Glass Cloth Laminate*

Among new, successful applications of Fiberglas reinforced plastics are the laminated orthopedic structures called ORTHO-PLY. Amazingly light and strong, the new splints and braces are comfortable to wear, rigid or flexible, as required, and may be adjusted within limits. Practical cases have been constructed across the nation and favorable reports made.

Formed over a cast of the part to be supported, the Fiberglas woven glass cloth or tape readily conforms to concave or convex body contours. Resin-laminated, the structure sets quickly and without pressure at room temperature. It is easily cleaned, may be chemically sterilized, is unaffected by perspiration. The glass fabric is chemically inert, and there is no known solvent for the resins.

Richard Quarles, M. D., employed on a Fellowship supported by Union Carbide & Carbon Corp., conceived the idea of ORTHO-PLY. Research was by Harold Weaver, M. D. Vernon-Benshoff Co., P.O. Box 1587, Pittsburgh 30, Penna., aided in developing rapid, simple techniques and offers materials for building ORTHO-PLY orthopedic braces.

New Scoliosis Jacket of Fiberglas woven glass cloth laminate . . . lighter, stronger, cleaner, more comfortable.

• • •

Inert, inorganic, nontoxic, nonallergenic, nonsensitizing and chemically and dimensionally stable, Fiberglas fibers produce no harmful effect on human tissue. Owens-Corning Fiberglas Corp., Dept. 30-G, Toledo 1, Ohio.

OWENS-CORNING FIBERGLAS

*Fiberglas is the trade-mark of Owens-Corning Fiberglas Corp., for a variety of products made of or with fibers of glass.

**What's in it for the M.D.? Is it scientifically sound? How good is the photography, the narration? To find out, a typical panel of experts reviews a new movie for the AMA Committee on Medical Motion Pictures.**

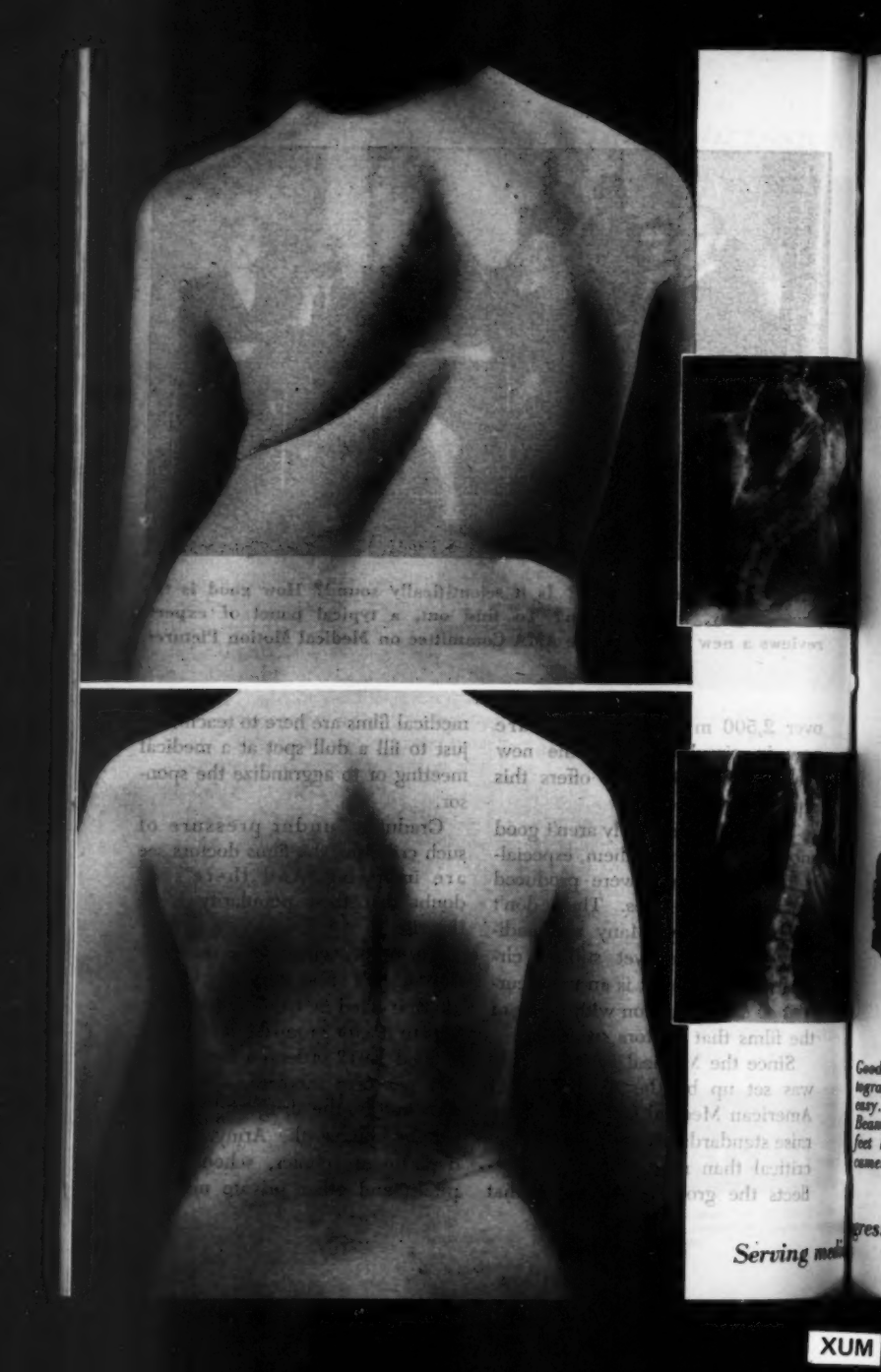
over 2,500 medical movies are now in circulation. But the new Medical Film Institute offers this explanation:

"Medical films simply aren't good enough yet. Lots of them, especially the older ones, were produced by visual illiterates. They don't teach effectively. Many are medically obsolescent yet still in circulation. The result is an undercurrent of dissatisfaction with many of the films that doctors see."

Since the Medical Film Institute was set up by the Association of American Medical Colleges to help raise standards, its approach is more critical than most. Its attitude reflects the growing conviction that medical films are here to teach—not just to fill a dull spot at a medical meeting or to aggrandize the sponsor.

Gradually, under pressure of such criticism, the films doctors see are improving. And there's no doubt that their popularity is on the rise.

For proof, consider the record of the AMA's film library. During 1946, it filled 804 orders for showings to doctor groups. During 1950, it filled 1,912 orders—a better than 125 per cent increase. Other film distributors—the drug and surgical supply houses; the Army medical department; clinics, schools, hospitals, and other private makers—



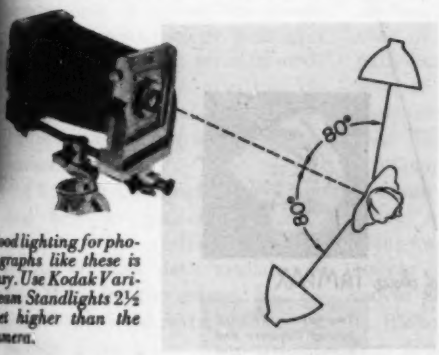
# Picture the patient

## *with photograph after photograph*

Today, in many hospitals, clinics, and physicians' offices, more and more cases are being photographed. Reason—because graphic records in black and white or color, still or motion, save time and space by reducing the necessity for written descriptive data . . . are accurate, long lasting, invaluable for diagnosis, teaching, research, reference.

And making medical photographs is easy . . . all you require is an efficient camera, reliable light source, dependable film. See your photographic dealer for further information, or write to Eastman Kodak Company, *Medical Division*, Rochester 4, N. Y.

***Kodak Master View Camera 4x5*** . . . To obtain "before and after" photographs such as those at left . . . for versatility in many other situations . . . to fulfill the complete still-camera requirements, Kodak Master View Camera 4x5 is ideal. With its multiple adjustments, light weight, compactness, choice of lenses, this unit, even for those who desire to make lantern slides, offers the utmost in convenience and utility.




*Good lighting for photographs like these is easy. Use Kodak Vari-Beam Standlights 2½ feet higher than the camera.*

*At your dealer's* . . . see also Kodak Flurolite Camera Combination, 2¼x 3¼; and other cameras in the Kodak line.

*gress through Photography and Radiography*

Kodak
TRADE-MARK

report similar step-ups in demand for their films.

Suppose you're a physician who wants a refresher course in a certain disease or surgical technique. Or a medical society officer planning a bang-up P.G. program. Or an M.D. doing your civic bit by giving lay health talks and civil defense instruction. For every such doctor in search of a film, the problem boils down to three questions: (1) How can I find the film I want? (2) How can I be sure the film is a good one? (3) How can I make the best use of the film?

### *Where to Get Help*

Best single source of information is the AMA Committee on Medical Motion Pictures, organized in 1946 to promote more widespread and intelligent use of medical films. From this committee (535 N. Dearborn St., Chicago 10), you can get free:

¶ Any of 145 mimeographed source lists of movies on specific subjects (anesthesiology, pediatrics, urology, orthopedics, physical medicine, atomic energy, civilian defense, etc.). Many of these lists include an abstract of what each film covers.

¶ Specific information on where and how to get every existing movie on any medical subject. Source of these data, available to any M.D. for the asking, is a recently completed AMA index of all medical films.

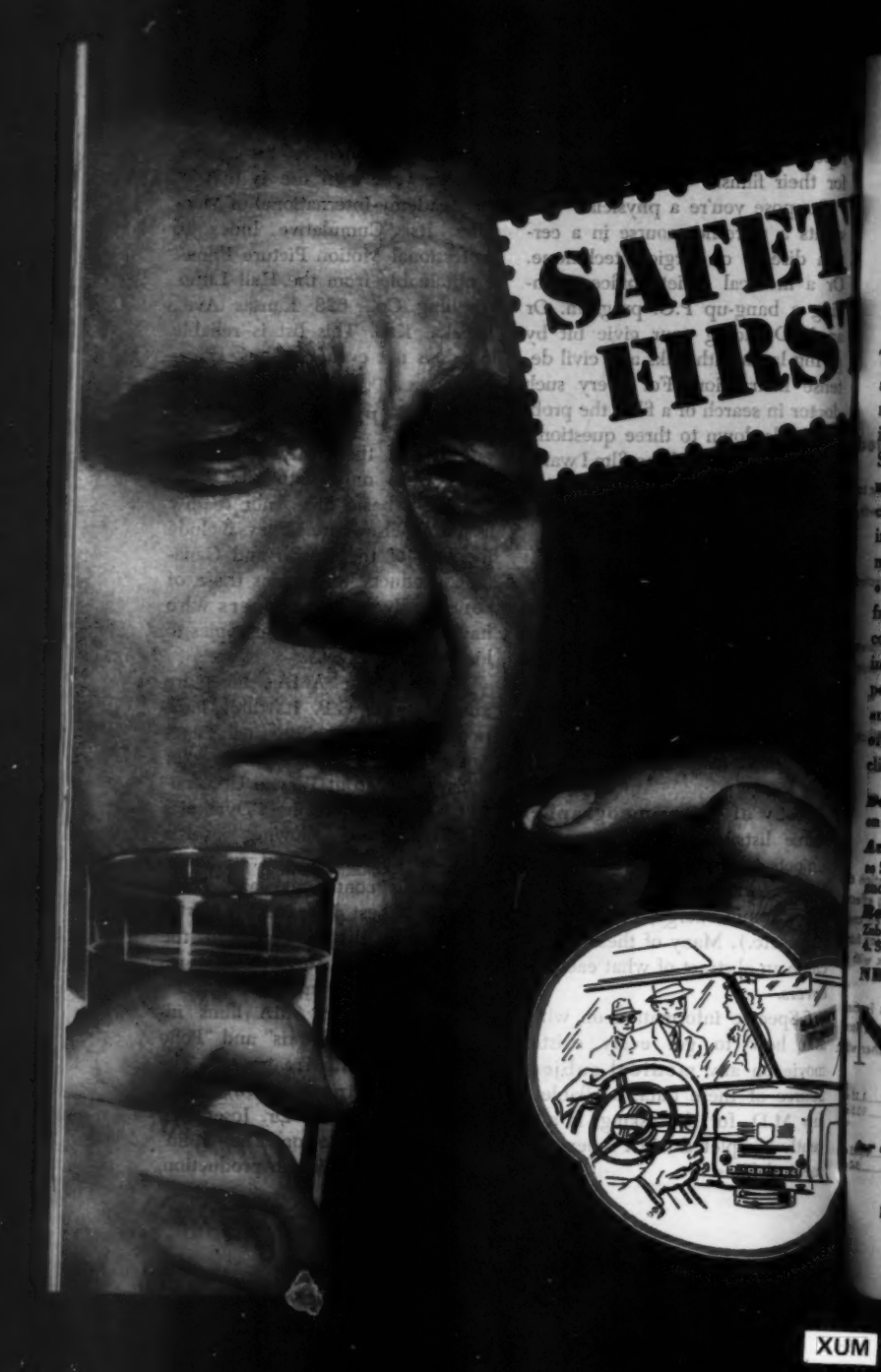
The only all-inclusive list you can buy for your own use is that of the Academy-International of Medicine. Its "Cumulative Index of Professional Motion Picture Films" is obtainable from the Hall Lithographing Co., 623 Kansas Ave., Topeka, Kan. This list is reliable but does not evaluate films. Price: $3.65.

### *Most Popular Films*

Although the AMA's own film library has only sixty-four titles, these are basic films, not readily available elsewhere. They include the best of the British and Canadian products, as well as those of some individual producers who have only one or two film copies to loan out themselves.

Many of the AMA's films are aimed at the G.P. Its three most popular titles are "Physical Diagnosis," a series of ten separate color films produced at Wayne University College of Medicine; "Dynamics of Respiration," showing respiration in anesthesia and in many pathologic conditions; and "Surgery in Chest Diseases," a forty-five-minute British guide to the best diagnostic, surgical, and rehabilitation techniques.

Other popular AMA films include "Angina Pectoris" and "Polio Diagnosis and Treatment." The former is a ninety-minute color movie prepared by Dr. Joseph E. F. Riseman of Boston. The "Polio" item is another British production,


SAFET
FIRST

# *in daytime antihistamine therapy*


The necessity of maintaining mental alertness under daytime antihistaminic medication should be a controlling factor in the choice of an antihistaminic agent. Sedation (the most common side effect of many antihistaminics[1,2]) can disturb concentration[1] and judgment,[4] cause failure in the operation of automobiles and other machines,[4] and lead to serious accidents.[3]

• Neohetramine offers a high degree of freedom from sedative effect.[1,2] Indeed, in a series of carefully controlled experiments on normal human subjects, Neohetramine in 50 mg. dosage "did not interfere with the efficiency of psychological test performance" in any of seven tests employed.[2] • For on-the-job alertness in antihistamine therapy, because of minimal sedation, prescribe Neohetramine. It may often be employed in cases intolerant to other antihistaminics. Yet its usefulness is clinically equivalent to that of other preparations. Professional samples on request.

***Dosage:*** Average dosage is 50 mg. to 100 mg. two to four times daily depending on response, severity of symptoms, and number of allergens present.

***Available:*** In 25 mg., 50 mg. and 100 mg. Tablets in bottles of 100 and 1000; as Syrup Neohetramine, providing 6.25 mg. per cc., in pint and gallon bottles; and as Cream Neohetramine 2% in 1 oz. tubes.

***References:*** 1. Feinberg, S. M.: Ann. N. Y. Acad. Sci. 50:1186 (April) 1950. 2. Landis, C. and Zubin, J.: J. Psychology 31:181 (April) 1951. 3. Schwartz, E.: Ann. Allergy 7:770 (Nov.-Dec.) 1949. 4. Sherman, W. B.: Bull. N. Y. Acad. M. 27:309 (May) 1951.

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***for effectiveness...for greater tolerance...in antihistamine therapy***

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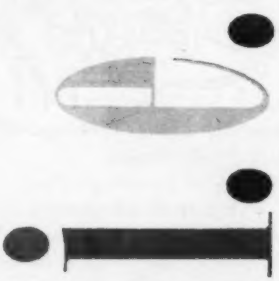
**wherever combined estrogen-androgen therapy is indicate**



**i.e.** in fractures and osteoporosis in either sex promote bone development, tissue grow and repair.

**i.e.** in the female climacteric in certain select cases.

**i.e.** in dysmenorrhea in an attempt to suppr ovulation on the basis that anovulato bleeding is usually painless.

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## "Premarin" with Methyltestosterone

**for combined estrogen-androgen therapy**

A steroid combination which permits utilization o both the complementary and the neutralizing effect of estrogen and androgen when administered co comitantly. Thus certain properties of either sex ho mone may be employed in the opposite sex with a minimum of side effects.

Availability: Each tablet provides estrogens in fix naturally occurring, water-soluble, conjugated fo expressed as sodium estrone sulfate, together wi methyltestosterone.

No. 579—Conjugated estrogens equine ("Premarin").....1.2 mg
Methyltestosterone .....10 mg
Bottles of 100 tablets (yellow)

No. 578—Conjugated estrogens equine ("Premarin").....0.62 mg
Methyltestosterone .....5 mg
Bottles of 100 tablets (red)

**Ayerst, McKenna & Harrison Limited**
**22 East 40th Street, New York 16, N. Y.**

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highly recommended by the AMA. For these and the other AMA-distributed films. there is a service charge of $1 to $5. The borrower also pays postal and insurance costs.

### *Is It Any Good?*

All other films must be ordered separately from the maker or distributor. Which raises a pivotal issue: How can you tell the good ones from the duds before ordering?

This the big question mark. No "Oscars" are awarded for medical films; no "Ten Best of the Year" are nominated. In fact, until the Journal AMA began to review movies about four years ago, it was pretty much a case of "let the borrower beware."

With many of the older movies, this is still true. With the newer releases, the JAMA reviews are an objective guide to technical quality, subject matter, and audience appeal.

The experts who scrutinize medical movies for the AMA pull few punches, hand out bouquets with restraint. For example, in reviewing a Brooklyn doctor's film on the subject of sterility, the AMA critics commented:

"The important parts would probably make a film of one-third the present length. The rest is largely an array of subtitles . . . so grossly defective as to spoil the film for any purpose whatever . . . Methods of treatment are named as having been 'used' without indicating whether they were found salutary or ruinous."

On the other hand, the reviewing committee hailed "Gastrointestinal Cancer," presented by the American Cancer Society, as a "well-organized film . . . The photography, animation, and narration are excellent . . . One of the highlights of this motion picture is the photographic record of what can be seen through the proctoscope and gastroscope . . . This film is highly recommended for county and state medical society meetings and has particular value to the G.P."

### *Critics' Evaluation*

More than 300 such reviews—all those published prior to 1951—have been reprinted in a special booklet and supplement. You can get them through the AMA's Order Department, at a cost of 25 cents.

Oldest of the evaluated film lists is that of the American College of Surgeons, 40 E. Erie St., Chicago 11. This is available free, but has certain shortcomings. The thousand-odd films on the list are merely those approved by ACS reviewing panels. Periodically, out-of-date films are supposed to be withdrawn from the list, but no "second reviews" have been made since 1943. It's reasonable to guess that the ACS list is dotted with some films of historical interest only. Example:

the therapeutic section of a malaria film produced in 1934.

Lack of up-to-date critical information on the hundreds of older films is a major problem for medical movie-goers. Their pick-and-choose problems are not made easier by these additional factors:

¶ Even the fact that a film was made recently does not guarantee that its medical concepts are up to date.

¶ Some films are focused on a particular drug or treatment. Later treatments may be missing; other possible therapies may be overlooked.

Can any doctor borrow a film for his own private use? In many cases, the answer is yes—although distributors generally prefer group showings. So do officials of the Medical Film Institute. Dr. Adolph Nichtenhouser, for example, says:

"A film may be biased, not scientifically valid—yet it may not seem controversial to the non-specialist. Because such a film may raise serious questions that affect a doctor's practice, it's better to arrange a

## How to Pooh-pooh Their Anxieties

"Now, now, Mrs. Oglesby, let's not let our imagination run away with us."

## Get Known as a Soapboxer

"Those knuckleheads and their social security . . . Why, if *they* ever had to meet a *payroll*! . . ."

seminar around any screening. At the very least, call in a specialist who can go beyond the film and make the showing more productive."

The AMA's Ralph Creer agrees: "The doctor's use of films to keep up to date clinically is best handled in group audience where informed discussion is possible with the subject still fresh in mind. These groups may be informal home gatherings, hospital staff meetings, county and state society affairs, or post-graduate seminars."

It isn't only in adding to professional know-how that movies have their place. The public-spirited doctor, speaking before civic clubs, adult education groups, or civil defense workers, often finds that the right film is a friend in need.

"You can't underestimate the public relations bonus to doctor and profession from this lay education work," says Creer. "But too few doctors realize what a lot of health education films are ready for their use."

Among outstanding films for the

## Repel Patients

### Never Mind How You Look

"Imagine that! She's switching to one of those glamour boys over on Archly Avenue . . . And for no reason!"

### Let Your Gal Patronize 'Em

"Doctah will see you now."


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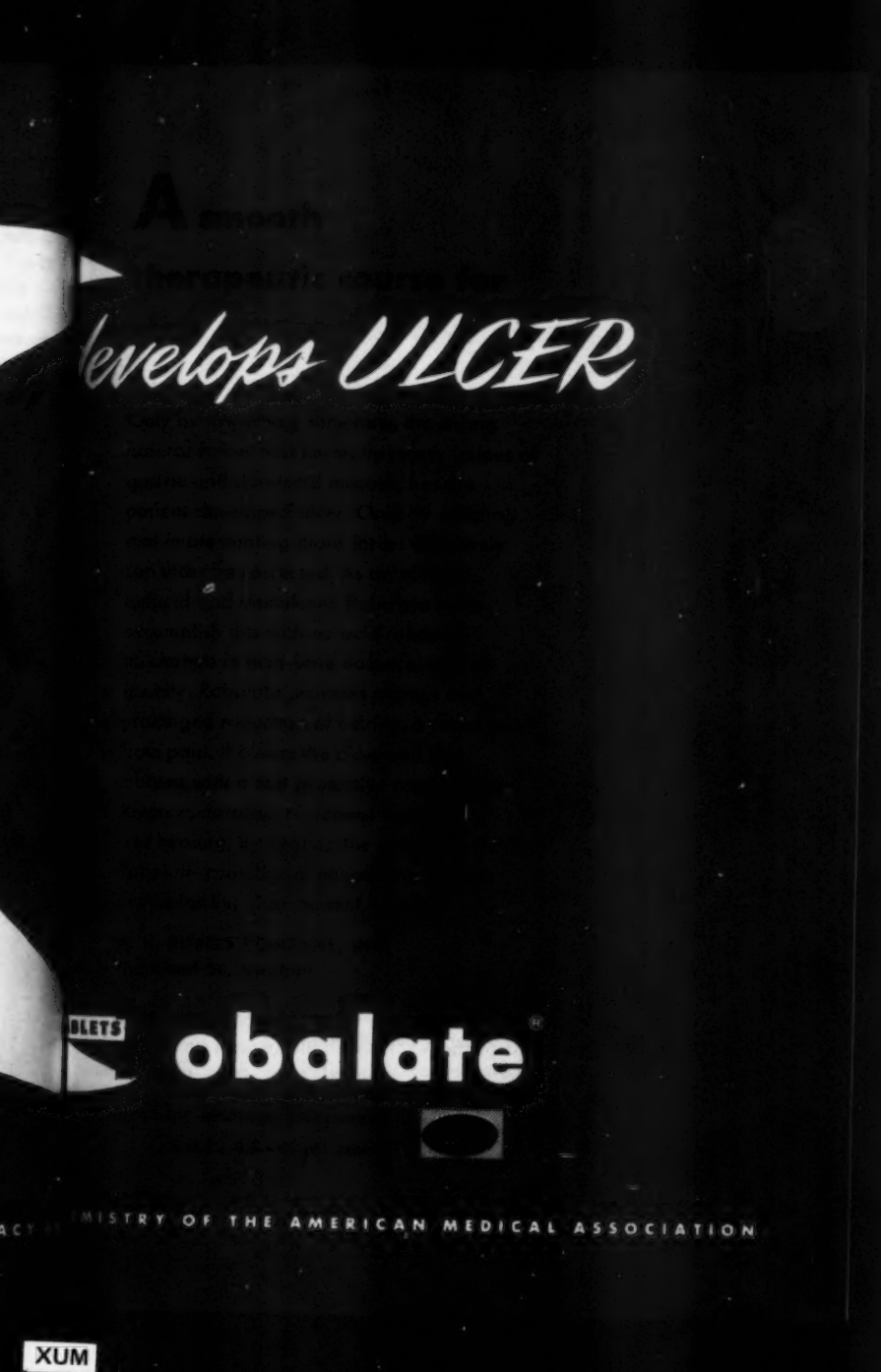
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MISTRY OF THE AMERICAN MEDICAL ASSOCIATION

laity, for example, are those of the March of Time Forum Edition, such as "New Frontiers of Medicine," dramatizing what's new in medical science; "A Life in Your Hands," the story of the national blood program; and "Modern Surgery," which promotes hospital-plan benefits through its story of an operation.

Practically every state health department keeps a library of such films. So do most state universities. But for basic information, call again on the AMA Medical Motion Picture Committee. They'll send you, gratis, a list of forty-six health movie distributors (insurance companies, health associations, government agencies, etc.).

### *Civil Defense Movies*

The AMA also has a few health and civil defense films for rental. Newest of these is "They Also Serve," a CD movie which, by pictorializing some of the worst disaster situations, seeks to jar citizen groups into action.

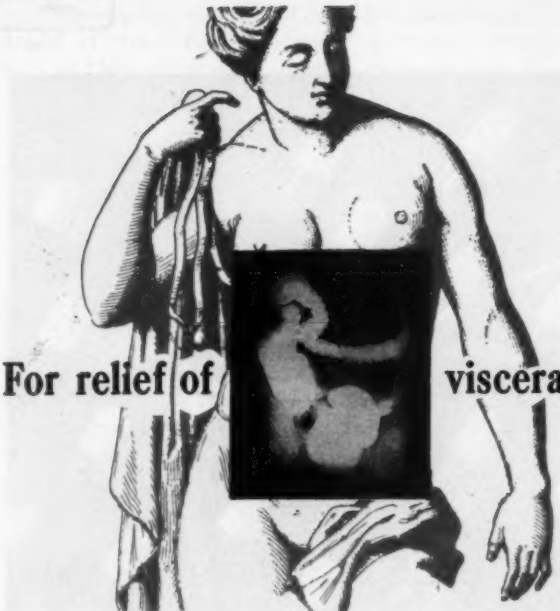
Latest wrinkle in medical films is Wyeth's "Tele-Clinics." These are forty-minute, newsreel-type movies of medical conventions—the top clinics and exhibits, scientific papers read by the authors, extracts of keynote addresses. First of these was shot at the World Medical Association meeting last October. The idea caught on and, last March and April, Wyeth filmed the annual meetings of the American Academy of General Practice and the American College of Surgeons. Prints are obtainable from Wyeth, Inc., 1600 Arch St., Philadelphia 3. You pay only return postage.

### *Film Futures*

What's ahead for professional films? Movie men look for two major developments: (1) improved teaching quality, with more subjects geared to G.P.'s; and (2) some form of centralized distribution.

To end today's piecemeal distribution system, Dr. David S. Ruhe, director of the Medical Film Institute, would like to see state health departments act as centralized distributing agents for most films. Whether this or some other method materializes, it won't happen overnight. You'll still have to wait a bit before you can write to a single distributor for any film you want.

As for the films themselves, Dr. Ruhe says: "Tell the general man not to get discouraged. The viewpoint of the G.P.—not just that of the pooh-bah scientists and specialists—is going to be expressed. There will be more and better films for him. But if he wants to hasten that day, let him speak up and express his dissatisfaction. Individually, or through his medical society, let him demand of a poor film's maker, sponsor, and distributor: Why was *this* film shown to me? Why wasn't a *better* one, geared to *my* interests, made for me in the first place?" END



## For relief of visceral spasm

In disturbances involving smooth muscle spasm, optimal therapy controls both the psychic and somatic factors involved. Trasentine-Phenobarbital, with components having both peripheral and central action, obtains therapeutic effect in moderate dosage, without the side effects of belladonna on the heart, pupil or salivary glands.

Trasentine-Phenobarbital has many indications in gastroenterology, gynecology, urology, and also in radiology where it is effective in controlling the symptoms of radiation sickness.

Issued: *Trasentine-Phenobarbital Tablets* (yellow) containing 50 mg. Trasentine® (adiphenine) hydrochloride with 20 mg. phenobarbital, in bottles of 100 and 500.

*Trasentine Tablets* (white) without phenobarbital, containing 75 mg., in bottles of 100 and 500.

# Trasentine-Phenobarbital

potent spasmolytic — mild sedative

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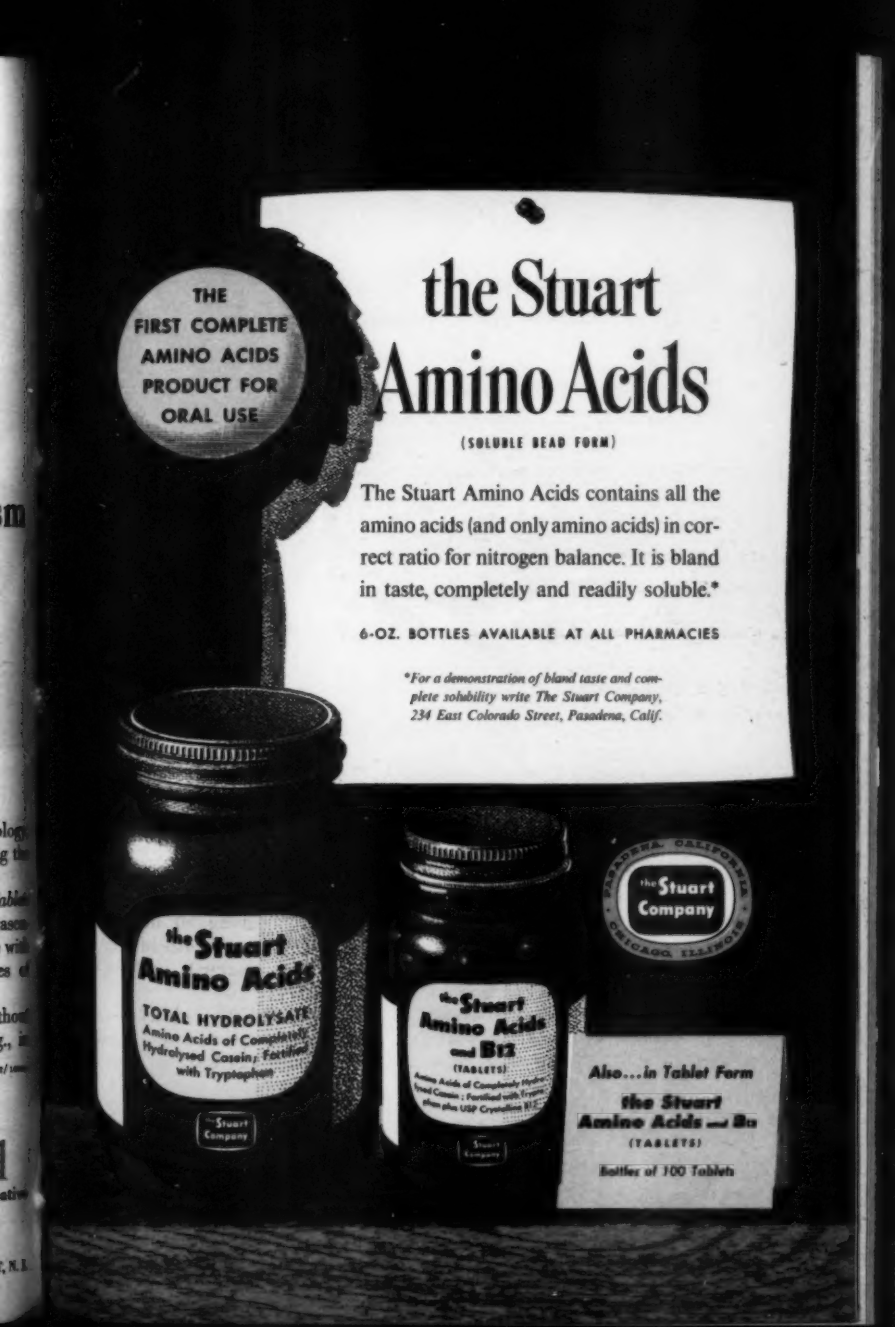
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The Stuart Amino Acids contains all the amino acids (and only amino acids) in correct ratio for nitrogen balance. It is bland in taste, completely and readily soluble.*
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# Your Insurance Questions Answered

***An insurance consultant sheds light on some of the posers raised by M.D.'s***

● QUESTION: *Suppose I trade in my old car and drive the new one without first notifying my automobile insurance company. Does my policy automatically cover the new car?*

ANSWER: Yes—for thirty days—provided that any other cars you own are insured by the same company. The standard car insurance policy gives you that amount of time to notify the company. During that period, your new car is covered.

QUESTION: *Is it worth-while to buy life insurance on my wife?*

ANSWER: It's a good idea ordinarily to consider a modest amount—say, $1,500 worth—to help absorb possible last-illness and burial costs. But if your wife accounts for an important part of the family earnings, you'll probably want to insure her for more.

QUESTION: *How about life insurance on my kids?*

ANSWER: There are conceivably two advantages in buying life insurance for a child: (1) You make sure that he'll have some protection later in life, even if ill health prevents him from getting any himself; and (2) you ease his premium burden somewhat when he's out on his own. The end cost of a policy is, of course, about the same no matter when it's taken out. But premiums are naturally smaller when payments are spread over a greater number of years.

QUESTION: *Suppose my home or office burns down. How will my fire insurance pay off—in cash value, replacement value, or what?*

ANSWER: You will get what the property is actually worth at the time (replacement cost less depreciation) *if* this total is covered by the amount of insurance you carry. Which means it's wise to adjust your coverage to changes in replacement cost minus depreciation.

QUESTION: *How are fire-damage claims handled?*

ANSWER: You report the claim to your broker or to the company direct. An adjuster is then assigned to your case. He will contact you about the details of the claim. END

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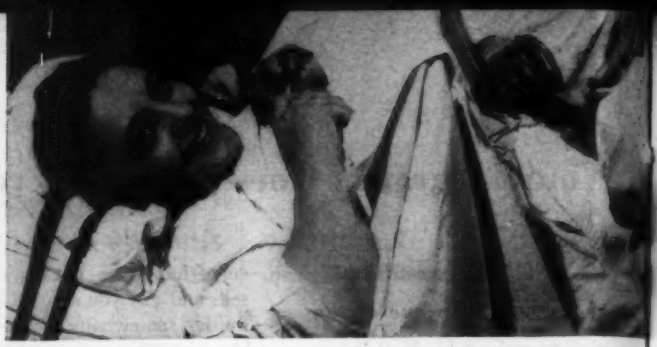
*By W. Clifford Klenk*

*Do you have an insurance problem that's of general interest? Questions are answered here, as space permits, by Mr. Klenk, a New York City insurance consultant.*



# Operation Camera

• Doctors have been known to operate on themselves. But until Mary Eleanor Browning came along, not even the most rambunctious shutterbug, while having a major operation himself, had ever photographed the entire process.

An unabashed professional, Miss Browning aimed to film her recent hysterectomy at Kew Gardens General Hospital, N.Y. Her surgeon—a bit dumfounded, yet fascinated by the idea—gave the patient permission to invade her own privacy.

The photographer bought a 22-inch mirror, had it wired to the boom light over the operating table. Then she took a spinal anesthetic, got a transfusion through a foot vein (thus leaving her arms free).

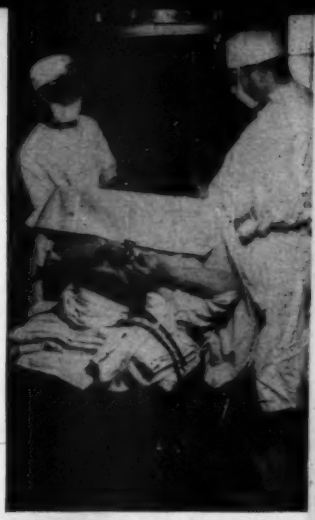
"Ready?" asked the surgeon. "O.K," said his patient.

The man with the knife made a quick, 10-inch incision. The woman with the camera filmed its mirror image overhead (pretending valiantly to herself all the while that she was looking at television).

Twenty-four shutter-snaps later, the first part of the operation—removing a tumor—was over. Here, the patient faltered, hiccoughed, gasped for breath. But revived by a few gulps of oxygen, she clicked on ("the camera weighed a ton") till the sutures were trimmed. Her afternoon's work: 108 exposures in 90 minutes on the table.

The operation was a success . . . but "Too much side lighting," said Photographer Browning in her best professional manner. "Not enough overall light for fast shutter speed."

END



"...completely amenable to cure"

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| Vitamin $B_6$ (pyridoxine) | 2 mg. |
| Calcium pantothenate | 10 mg. |
| Nicotinamide | 150 mg. |
| Vitamin C (ascorbic acid) | 150 mg. |
| Vitamin $D_2$ (calciferol) | 1,000 units |

*One or two capsules of* PLURAXIN *daily usually suffice*

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*Wilbur, D. L.: Principles in the Use of Vitamins in Treatment: I. Vitamin Deficiency Diseases. Gastroenterology, 1:179, Feb., 1943.

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# How Good Are the Voluntary Plans?

***Senate health subcommittee gets a new progress report on medical prepayment***

• Now that 75 million Americans are insured for some part of their hospital bills, and 52 million of these are partly protected against medical-surgical costs, it's clear to almost everybody that "the growth of medical-care insurance in the U.S. is one of the most significant social developments of recent years."

But do these impressive figures tell the whole story? Not entirely. Still uninsured is about 80 per cent of the nation's potentially-insurable medical-care bill. Still relatively unprotected are low-income families, whose medical needs are greatest.

That's the gist of a staff report on "Health Insurance Plans in the U.S." recently delivered to the Senate Subcommittee on Health. This report probably amounts to the most complete study of voluntary health insurance since it became big business.

Prepared under the direction of Dr. Dean A. Clark, the study shows a marked bias in favor of group practice and lay-sponsored, comprehensive-benefit plans. This, of course, reflects Dr. Clark's past experience as medical director of New York's Health Insurance Plan (he's now director of Massachusetts General Hospital). But the Clark Report also provides a wealth of straight facts for doctors and legislators to ponder.

For example, here's how it classifies the 75 million people who, at the beginning of this year, carried hospitalization insurance:

¶ About half were covered by Blue Cross, which paid 69 per cent of the average subscriber's hospital bills.

¶ The other half were covered by commercial insurance companies, which paid 47 per cent of the average subscriber's hospital bills.

And here's how the Clark Report classifies the 52 million people protected to some extent by medical-surgical insurance at the beginning of this year:

¶ Almost one-third were insured with Blue Shield plans, which paid 44 per cent of the average subscriber's doctor bills.

¶ Almost two-thirds were insured with commercial carriers, which paid, on the average, 45 per cent of the *group* subscriber's doctor

***By John Byrne***

# FROM Curity POLISHING...

## the right smoothness for sure knot-holding

It is mandatory in hysterectomy or any surgical procedure that the suture knots must hold until the healing tissues can take over.

And a suture's knot-holding qualities depend almost entirely on the right finish, the right coefficient of friction.

Sure knot-holding is "built in" in all *Curity* catgut sutures by the *Curity* polishing method . . . which removes any whiskers, produces a smooth surface, assures secure knots in the most delicate suturing procedures.

It does not produce the surface weaknesses found in an overpolished strand . . . nor does this method grind the suture down to a gauge. *Curity* polishing gives just the *right* smoothness to the strand surface, retaining the full tensile strength of the suture.

This polishing process is another contribution to the science of suture making from the laboratory that, through the years, has made so many important contributions in your interest.

Curity
SUTURES

Your hands will tell you, with the first knot you tie in a *Curity* Suture, that here is the finish a fine suture strand should have.

bills (42 per cent of the *individual* subscriber's doctor bills).

Into a separate and special category go nearly 4 million Americans who get comprehensive benefits (hospital, surgical, *and* medical) through "independent" plans—those sponsored by co-ops, unions, farmers, and other lay groups. Such plans pay from 80 to 90 per cent of all physician and hospital bills incurred by subscribers, Dr. Clark estimates.

### *Only Part Way*

How big a dent does health insurance make in the nation's annual medical bill? Not very big as yet. "Of the $9 to $10 billion expended for medical care in 1949, medical-care insurance paid [only] about $770 million. Taxes [paid] $2 billion, and non-insured private expenditures [accounted for] $6 to $7 billion . . . "

Who are the people who aren't yet insured? No one knows exactly, but the Clark Report makes a stab at the answer. "Certain categories of people are difficult to insure," Dr. Clark points out, mentioning in particular rural residents, the self-employed, people over 65, people with existing disabilities, and most low-income families.

Dean Clark has quite a bit to say about doctors' fees. Here's a sample:

"One of the difficulties in making use of the fee-for-service sys-

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**"You mean Fifi La Belle? . . . THE Fifi La Belle?"**

PHOSPHO-SODA (FLEET)

THE LAXATIVE FOR *judicious* THERAPY

*because* of its

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Phospho-Soda (Fleet)'s* action is prompt and thorough, free from any disturbing side effects. That's why so many modern authoritative clinicians endorse it... why so many thousands of physicians rely on it for effective, yet judicious relief of constipation. Liberal samples will be supplied on request.

*Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 Gm. and sodium phosphate 18 Gm. Both 'Phospho-Soda' and 'Fleet' are registered trade marks of C. B. Fleet Company, Inc.

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tem is the fact that fee schedules for physicians' services have not usually been based on the assumption that all of a physician's patients had insurance which would surely pay the entire amount specified... Thus, a fee of $150 for the repair of a hernia does not seem unreasonable. But if the average surgeon did nothing but perform 200 such repairs a year (which is easily within the limits of time and competence for a well-qualified surgeon) and were paid the full insurance fee for each, his annual income for this work alone would be $30,000.

### *New Fee Schedules*

"One is bound to conclude that, as a greater proportion of the population becomes insured, either some method of payment other than fee-for-service must be found or the fee schedules must be greatly revised."

But despite these reservations about the present health insurance system, Dr. Clark concedes its great gains. He notes a trend toward "reduction in the number of exclusions ... broadening the types of protection ... increasing of the dollar value of the benefits." He refers to the "striking increase in the number of people who have been reached."

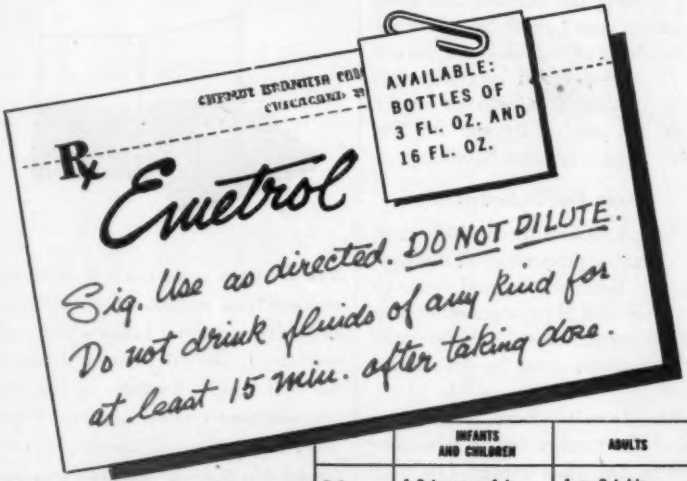
He winds up on a note that suggests the public, at least, thinks pretty well of the voluntary plans: "Prospects appear to be good for further increases in enrollment ... especially because of the emphasis being put on this type of insurance in collective bargaining." END

# FOR RAPID...SAFE...PHYSIOLOGIC CONTROL OF FUNCTIONAL VOMITING

## EMETROL®

PHOSPHORATED CARBOHYDRATE SOLUTION

- before and after anesthesia
- in early pregnancy
- in epidemic vomiting




EMETROL is a phosphorated carbohydrate solution which controls functional vomiting through a unique physiologic action. Clinical findings have established its broad therapeutic effectiveness.[1]

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| | INFANTS AND CHILDREN | ADULTS |
|---|---|---|
| Before and after anesthesia | 1-3 teaspoonfuls 15-30 minutes before anesthesia and as soon as feasible after operation | 1 or 2 tablespoonfuls at same intervals as for children |
| Early pregnancy | | 1 or 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens |
| Epidemic vomiting | 1 or 2 teaspoonfuls at 15-minute intervals until vomiting ceases | 1 or 2 tablespoonfuls at 15-minute intervals until vomiting ceases |

1. Bradley, J. E., et al.: J. Pediat. 38: 41 (Jan.) 1951

LITERATURE AND SAMPLES TO PHYSICIANS ON REQUEST

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# TRUSTS and What They Offer

• Why set up a trust? In general, for any or all of these purposes: (1) to save taxes, (2) to obtain expert investment management, (3) to control the disposition of your estate in the light of contingencies that may arise after your death.

A trust can be established by will, in which case it's called a *testamentary* trust. Or you can set one up while you're still alive and kicking; then it's known as a *living* trust. Moreover, the living trust can be designed to continue after your death.

For either kind of trust, here's the cast of characters:

¶ The *donor* (or *settlor* or *grantor*), who creates the trust.

¶ The *trustee*, who runs it.

¶ The *income beneficiary*, who gets the income.

¶ The *remainderman*, who gets the principal when the trust ceases.

There can be more than one of any of these parties—more than one donor, trustee, income beneficiary, or remainderman. And one person can play more than one role. The donor, for instance, can name himself a trustee. He can reserve to himself either an income right or a remainder right. Or one of the beneficiaries can be a trustee. Numerous combinations are possible.

Testamentary trusts and living trusts work in much the same way. While the donor of a living trust can appoint himself trustee, the usual arrangement is that based on a contract between the donor and a separate trustee. This is called the *trust agreement*.

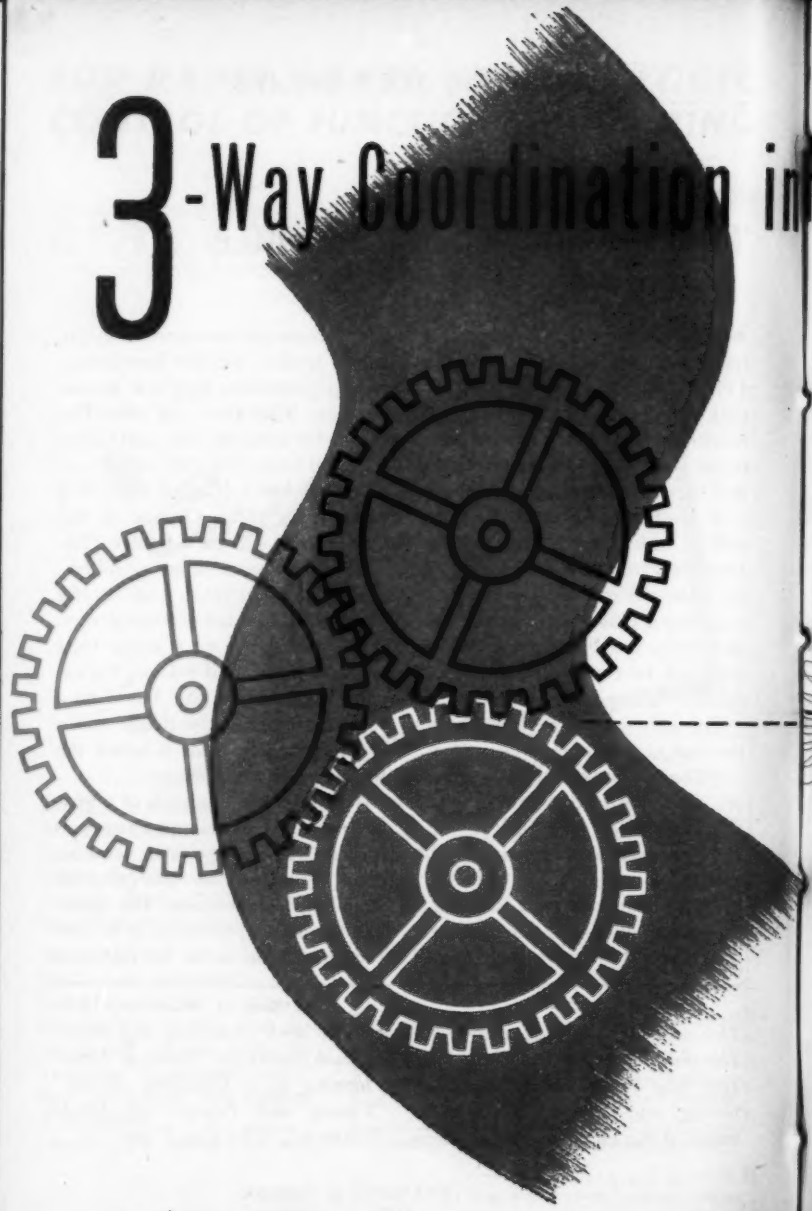
What are the essentials of a trust agreement? Certain property is turned over to the trustee, who accepts it *in trust* for the purposes stated in the agreement. The agreement contains provisions as to how the trust fund is to be managed

---

*This article is the fifth of a series. The author combines a busy New York law practice with teaching, writing, and lecturing. He is moderator of the estate-planning course*

*By Rene A. Wormser, LL.B. at New York University and author of such books as "Personal Estate Planning in a Changing World," "Theory and Practice of Estate Planning," "The Law," etc.*

# 3-Way Coordination in Hy



# in Hypertension Control...

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Coordinating effectively with your over-all plan of hypotensive treatment, Rutol provides safe drug medication designed to satisfy these vital objectives:

**1 • SEDATION**

**2 • VASODILATION**

**3 • CAPILLARY SUPPORT**

Combined sedation and vasodilation are provided by the central effect of Phenobarbital and the direct, smooth muscle relaxing action of mannitol hexanitrate. Protection against capillary fragility[1] is provided by rutin—most active member of the flavone glucosides.

*Each Tablet of Rutol contains:*

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| Mannitol Hexanitrate | 16 mg. (1/4 gr.) |
| Rutin | 10 mg. (1/6 gr. approx.) |
| Phenobarbital | 8 mg. (1/8 gr.) |

*Supplied in bottles of 100, 500 and 1000 tablets.*

1. Donegan, J. M., and Thomas, W. A.: Capillary Fragility and Cutaneous Lymphatic Flow in Relation to Systemic and Retinal Vascular Manifestations: Rutin Therapy, Amer. J. Ophthalmology 31:671-78 (June) 1948.

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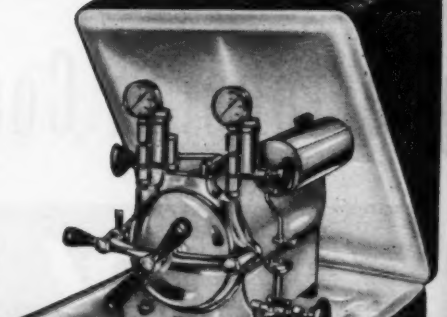
*The Office Jewel You'll be Proud to Own... with the* **SPEED** *and* **SAFETY** *You'll Prize*



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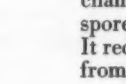
Here is equipment that not only dignifies and decorates the professional office, but, at the same time, dispels fear of post-operative infection. Its 6 by 12-inch pressure chamber offers the ultimate in positive destruction of spore-bearing bacteria. And the FL-2 is as *fast* as it is *safe*. It reduces the time between consecutive sterilizing periods from many minutes to seconds.

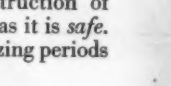


MODEL 70

### SPECIAL PELTON CABINETS for FL-2 AUTOCLAVE

These two new Pelton cabinets have been specially designed to accommodate the FL-2. Graceful lines and quality construction are in keeping with the Autoclave's beauty and efficiency.

***The FL-2 is a long-time investment. You will not regret waiting for delivery.***



MODEL 40

# PELTON

THE PELTON & CRANE CO., DETROIT 2, MICHIGAN

and the trustee's fee is stipulated, generally on a percentage basis.

The trust agreement must also specify: (1) when and to whom the income is to be paid, (2) when the trust is to terminate, and (3) who then gets the principal.

How safe are you in creating a trust? The responsibility placed on a trustee by law is severe. He is not an ordinary debtor, since he cannot escape liability by going through bankruptcy. He is held to strict account for any gross negligence or mismanagement. He may even go to jail for abuse of his trust.

Even so, it is obviously necessary to select a trustee in whom you have complete confidence as to character, judgment, and stability. Many donors appoint a bank or trust company as trustee.

There are two types of living trust: *revocable* and *irrevocable*. In the first, the donor can amend or terminate the trust agreement at any time. In the second, the donor can't change his mind once the trust is set up. It is unwise for a donor to make a living trust irrevocable unless there are strong reasons for it and he is well aware of what he's doing.

A man's motives in creating a trust are generally protective. He's aiming for either his own protection or someone else's. An inexperienced investor, for example, may want to turn over the management of his holdings to an expert. He can do this through a living trust. And if he wants the same sort of protection for his wife when he dies, he can provide that the trust continue.

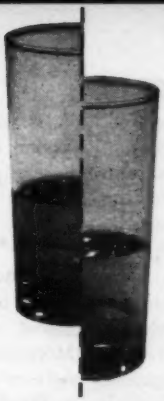
### *Uses of Living Trusts*

A trust agreement of this kind acts as a substitute for a will, to the extent of the property involved. Moreover, there's no wait for the wife or other heirs, corresponding to the delay caused by a will being probated.

Here's another way a living trust can be useful:

Suppose you support your aged Uncle Charlie to the tune of $2,000 a year. If you have already accumulated a sufficient estate, you can establish an irrevocable trust for his income benefit, with the principal going to your children at his death. It will take less in invested funds to earn the $2,000 for Uncle Charlie

PENETRATING!



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for that sore, irritated throat?...


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THERAPEUTIC GARGLE

*Cēpacol is widely prescribed and recommended for:*

- Sore throat associated with the common cold and influenza
- Tonsillitis
- Pharyngitis
- Pre- and post-tonsillectomy
- Irritation from postnasal drip

*Alkaline, non-toxic . . . ideal for daily use as gargle or spray.*

# Yes!

Better penetrating and cleansing action is assured with *Cēpacol*. Its lower surface tension (33 dynes/cm.) enables it to penetrate into the recesses and folds of the mucosa . . . to cleanse more deeply, more thoroughly.

# Yes!

Effective antibacterial cleansing can accompany this mechanical cleansing, too. *Cēpacol's* safer, more powerful antibacterial agent (Ceepryn ® Chloride) kills a wide range of oral bacteria within 15 seconds after contact, according to laboratory tests.

*And Cēpacol has a decidedly pleasant taste*

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(Pronounced "Seep-a-call")

**THE PLEASANT, DOUBLE-CLEANSING ANTIBACTERIAL GARGLE**

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NOW AVAILABLE . . . Cēpacol Throat Lozenges! *These convenient, pleasant-tasting lozenges, dissolved slowly in mouth, provide a soothing, analgesic solution to relieve the dryness and irritation of sore throat.*

**IN VAGINAL AND CERVICAL SURGERY**

Furacin Vaginal Suppositories are being used preoperatively to eradicate accessible bacterial infections of the cervix and vagina.

Postoperatively, following hysterectomy or conization of the cervix, their use facilitates primary healing by controlling the surface infection. Likewise, they can decrease greatly the slough, drainage and malodor.

Furacin is stable at body temperature —remains effective in the presence of exudates—is bactericidal to a wide variety of gram-negative and gram-positive pathogens.

*Furacin® Vaginal Suppositories*

**TO DECREASE DRAINAGE**
**TO MINIMIZE MALODOR**
**TO FACILITATE HEALING**

Furacin Vaginal Suppositories contain Furacin 0.2%, brand of nitrofurazone N.N.R. in a base which is self-emulsifying in vaginal fluids and which clings tenaciously to the mucosa. Each suppository is hermetically sealed in foil which is leak-proof even in hot weather. They are stable and simple to use.

These suppositories are indicated for bacterial cervicitis and vaginitis, pre- and postoperatively in cervical and vaginal surgery.

*Literature on request*

The NITROFURANS
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A unique class of antimicrobials

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NORWICH, NEW YORK

this way, since *he'll* be paying the income taxes on it—at a lower rate than that for *your* income bracket.

Through the same kind of set-up, you can provide for the care of a niece until she is married. Or a widowed sister until her sons are working.

Sometimes there are less obvious reasons for creating a living trust. To take a rather unpleasant example:

A fictional fellow we'll call Dr. Grudgesome is married to a woman who is making his life miserable. He'd like to cut her off with as little as possible—but the law in his state entitles a widow to at least a third of her husband's estate. Grudgesome's answer: a trust designed to take a large part of his property out of his estate. This reduces the testamentary fund from which his wife may take the slice allowed her by law.

Suppose you wish to provide for someone—perhaps an incompetent near relative—without actually naming him in your will. A trust serves very well here. For though a will becomes a public document at the testator's death—available to newspaper reporters or anyone else—a trust agreement remains strictly private.

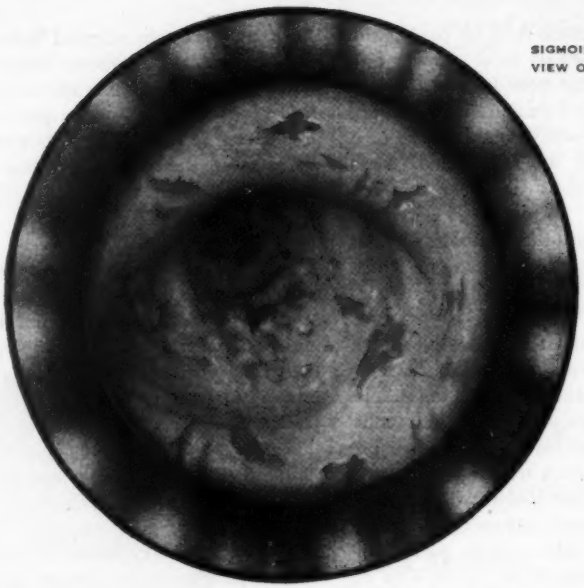
How long may a trust last? This brings up something called *the rule against perpetuities.*

The rule varies from one state to another; but the basic principle is that a trust cannot last longer than the lives of certain selected living persons. Just to complicate things, there's an additional time allowance of "twenty-one years and a period of gestation." But let your lawyer worry about the fine points. Here's what they add up to:

### *Till Death's Parting*

You cannot create a trust to last for ten years or twenty years or any other period of calendar time. It must be governed instead by the lives of people (beneficiaries or otherwise) who are living when the trust comes into effect. Subject to this proviso, however, there's no limit on the number of successive income beneficiaries you may name.

To illustrate: You can have a trust pay income to dozens of successive people, if you choose, provided only that the trust terminate and the principal be payable to a designated remainderman on the demise of some specified person—*e.g.*, "upon the death of the last to



SIGMOIDOSCOPIC
VIEW OF RECTUM

*in dysentery due to Shigella paradysenteriae:*

"Six children between the ages of four and six years . . . given terramycin. The diarrhea which was pronounced in each case stopped within 48 hours in the case of four patients and within 72 hours in the other two . . . In all cases, the organism disappeared from the stool after treatment was started and did not reappear."[1]

*Dowling, H. F., et al.: Ann. New York Acad. Sc. 53:433 (Sept. 15) 1950.*

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE *available as Capsules, Elixir, Oral Drops, Intravenous, Ophthalmic Ointment, Ophthalmic Solution.*

ANTIBIOTIC DIVISION **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, N.Y.*

die of my six children, Mary, Joe, John, Henry, Gladys, and Louise."

But a word of caution: Your state may have its own peculiar rule of perpetuities. In New York, for example, the measuring lives may be only two. On the death of the last to die of two named persons, the principal must go outright to the remainderman (unless he's a minor; in that case it can be kept in trust until he attains majority).

### *Keep It Clear*

It is not necessary for everyone named in a trust to share equally. You may divide the income or principal payments in any way you wish, as long as the trust agreement makes intelligible sense.

You can, if you feel like it, create a trust to provide that during the life of Mary, the income shall be paid to the tenants of 133 West 11th Street in New York City; that adults shall take twice the share of minors, and those born in New York City an extra 10 per cent; that during Joe's life, the income shall be paid one-third to Charlie and two-thirds to his mother-in-law; and that during the life of Louise, the income shall be paid equally to all the full professors at Hillsdale College of Medicine.

An absurd example, but it gives you some idea of how far you can go. It also illustrates the fact that you can put conditions on your payments.

You can go even further in setting up conditions. You can limit the beneficiary professors to those who do not divorce their wives, or to those who have not become swamis, or to those who breed cocker spaniels. The only limitation is that your conditions must not be against public policy.

What would be against public policy? Well, perhaps a stipulation that the beneficiary loses his payments if he gets married. Anything tending to coerce a beneficiary into an asocial course of action would probably be voided.

Apart from that, you are free to direct that payments to beneficiaries either begin or end as certain specified circumstances arise. Thus, you can have Mary taken care of until she is able to support herself; or, conversely, you can provide that payments shall be made to her if and when she cannot support herself. You have almost unlimited scope in the manner in which either income or principal is to be paid out. (Payments of principal, incidentally, need not await the termination of the trust if you want to provide otherwise.)

### *Check Your State Law*

In most states, the income of a trust can be accumulated during such periods as you direct. That is, the income may be kept in trust and added to principal, instead of being paid out. In such states, you can give a trustee discretion to pay out income to the beneficiaries

when he finds need and to accumulate it at other times.

Sometimes this question comes up: Under the law of what state is your trust to be administered?

Generally, a testamentary trust is governed by the law of the state in which the donor was domiciled at his death. A living trust is governed by the law of the state in which it was created.

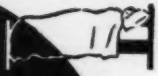
But there are exceptions. Location of the property may have a bearing; with real estate, it is *always* the state of location that controls. Again, a trustee's place of residence may affect the problem; a court in the trustee's state may decide to apply its own law, even though the trust was set up in another state. Such matters should be considered in advance if possible.

One of the most valuable features of a trust in planning your estate is the discretion you can give your trustees. You can empower them to pay out principal to your wife if she needs it, but otherwise to pay her only the income, preserving the principal for your children. Or you can make your children income beneficiaries in succession to her, preserving the principal for your grandchildren.

There can be great tax savings in arrangements of this sort. But that's a subject in itself, to be covered in a later article. END

MEDICAL ECONOMICS

**"I always bill my women patients for an amount like $39.95, $24.75, or $99.50 . . . Makes it sound like a bargain."**



While the patient lies abed

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With the addition of hexachlorophene, effective germicidal and deodorant agent of low toxicity, Dermassage has acquired greater protective value. It makes possible a lowered bacterial count on skin areas to which it is routinely applied, thus minimizing the risk of initial infection should skin breaks occur in spite of precautions.

**An efficient means of protecting the patient against skin discomfort or damage while confined to bed or wheel chair in hospital or home. Used and approved in thousands of hospitals, coast-to-coast, and on the recommendation of doctors, nurses and hospitals to patients returning home.**

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Please send me, WITHOUT OBLIGATION, your Professional Sample of Dermassage.

**Name**.....

**Address**.....

# Jottings From a Doctor's Journal

● It has come to Bill Goslin, thorough and competent doctor that he is, to taste the tartness of humility. On the chart of a colored woman attending the cardiac clinic he had written the note: "Cardiac findings unchanged. Continue dig., two cat units daily."

At the next clinic session, student John Lyman, chart in hand, brings the woman over and says apologetically: "Excuse me, Dr. Goslin, but you saw this woman last week. What's this on her breast?"

The breast shows obvious distortion of outline, the tell-tale *peau d'orange*, beginning ulceration—far-advanced carcinoma.

Goslin's face speaks many things before he says, "Thanks, Son. I missed this last time."

• • •

For the tracheal compression caused by Paul Harrin's aneurysm, the heroic measure of removing the three upper ribs was decided on. Just as elderly Dr. Ramsey finished scrubbing, the problem unexpectedly solved itself in a sudden massive hemoptysis from the ruptured aneurysm.

Dr. Ramsey, gazing upon Mr. Harrin's remains, continued to dry his hands deliberately, then spoke:

"I'm reminded by this that some of the younger men around here have had a little fun about my habit of taking ten full minutes to scrub. Here is a lesson for them to remember. If I had scrubbed a little less, someone might be suing me for a million dollars."

• • •

For inflating your sense of importance, there's nothing like having your picture in the paper.

The gentleman who had swooned on the stage and had come to as if in response to my efforts, was dazed but volubly appreciative. So when the photographer's flash went off, I felt rather like planting one foot on the victim's chest and emitting the ancestral victory cry.

However, since perfection in this sad world is not, the newspaper misspelled my name, printed my address wrong by two streets, and deliberately retouched my picture to double the size of my bald spot.

• • •

In the absence of patients, Ludwig Hasterack's way of breaking in new equipment is to test it on members of his household. As a result, the maid who submitted to

***By Martin O. Gannett, M.D.***

# SMOOTHER CERVICAL CONIZATION

*with the*

# BIRTCHER BLENDTOME

Frequent necessity of cervical repair suggests the practicality of having a BLENDTOME ELECTROSURGICAL Unit in the office or clinic. With this instrument, the doctor is enabled to do a smoother cervical conization. The BLENDTOME cuts and coagulates simultaneously with a blended current. Scar and other tissue is cut through quickly and easily; blood and lymph vessels are almost instantly sealed. The cleaner field results in reduced trauma and operative shock, smoother convalescence and more rapid healing.

The Birtcher BLENDTOME was *designed* for use in the doctor's office or private clinic. It provides electrosurgery for all but the strictly major cases. There are many everyday uses for the BLENDTOME—any case indicating fast and sure cutting with simultaneous sealing off of blood and lymph vessels.

Consider how much more you would be able to do with the ease, timesaving and effectiveness of a Birtcher BLENDTOME in your own office. Write for literature.

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treatment of her lumbago is eating from the mantlepiece because of a short-wave burn in a strategic location; Mrs. Hasterack is desquamating freely after exposure to the ultra-violet lamp; and now the doctor's mother-in-law has broken off diplomatic relations.

It seems the son-in-law had just acquired an ECG machine and innocently asked the lady to sit in the chair. No sooner did he approach with the electrodes than she leaped from the chair and ran.

"Trust him? I should say not. I could read his mind: Get me in the electric chair, then just make a little mistake. No thanks!"

• • •

His very first morning on the ward, as I made ready to go over him, Mr. Jillett confided in me that he could hear his heart leaking. Well, I thought, maybe. A congenital anomaly might set up enough noise for that. Only he didn't have one.

Two days later, he trotted out another of his occult powers. It seems he could feel the muscles contract around his pupil when I flashed a light in his eye—the other pupil remaining unconcerned.

This morning at rounds he called to me: "Say, Doctor, mind if I ask you something? Is it true that there's pipes from the kidneys to the bladder? I thought so. You know something—here I've been lying in bed all morning, and I can just feel about once a minute a drop from each pipe fall off into the bladder. There's a little splash like . . . "

• • •

Ned Saley, bald, brisk, and mercurial, stops me for an intimate *tete-a-tete*:

"I hope you don't think I'm like them other patients, Doctor. I know just what medicine you're giving me, and it's the right stuff, too. Only one thing—that belladonna. Is it really the best drug for my condition? Don't you think atropine would be better?"

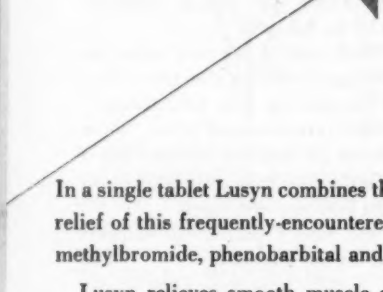
"Well, now. I see you know the difference between the two. How did you pick up your information?"

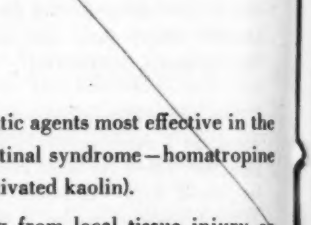
"Oh, it come natural to me. Never went to no college, neither. But I worked a couple years for the AMA, and I kept my eyes open.

"My job? I pasted the address slips on the journals." END


**"After all, if he can't even keep a plant alive . . ."**

***a 3-pronged attack on gastrointestinal spasticity, hyperacidity, and psychosomatic disturbances***





In a single tablet Lusyn combines three therapeutic agents most effective in the relief of this frequently-encountered gastrointestinal syndrome—homatropine methylbromide, phenobarbital and alukalin (activated kaolin).

Lusyn relieves smooth muscle spasm arising from local tissue injury or psychosomatic disturbance. It is an effective spasmolytic agent in cardiospasm, pylorospasm and irritable colon. Homatropine methylbromide, the antispasmodic in Lusyn, produces no atropine-like side effects.

Lusyn neutralizes excess acid and spreads a fine, soothing, protective film over the inflamed gastric mucosa without alkalosis or acid rebound.

Lusyn takes the edge off "nervous tension" which is frequently associated with muscle spasm.

*Formula:* Homatropine methylbromide . . . 1/24 gr., Phenobarbital . . . 1/8 gr., Alukalin (activated Kaolin) . . . 5 gr. *Dosage:* Usually, 1 or 2 Lusyn tablets before meals.

# Lusyn®

***antispasmodic . . . sedative . . . antacid adsorbent***

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# Two Views on the 'Doctor Shortage'

**• Two national magazines hit the newsstands on the same day a month ago with feature articles giving widely divergent slants on the alleged doctor shortage. In The Saturday Evening Post, Dr. Franklin Murphy, dean of the University of Kansas School of Medicine, declared: "We Need More Doctors." In Reader's Digest, Paul de Kruif took an opposing view: He declared there was nothing approaching a medical manpower crisis in sight. Here, in topical form, is a condensed version of what each man had to say.**

### *Is There Really Such a Thing As a Doctor Shortage?*

MURPHY: The realization that our medical needs are growing faster than our medical manpower has been bothering many of us for several years. How big the deficit really is depends on who makes the estimate. The American Medical Association, until recently, has denied the existence of a shortage and suggested we might be in for a surplus instead. Others have said it was all simply a matter of uneven distribution of physicians.

But over and above this faulty distribution there is, in the opinion of many medical educators, an absolute and substantial numerical shortage of trained medical personnel. I believe this was true even before the Korean crisis.

DE KRUIF: "Our Alarming Doctor Shortage"—So runs the title of a recent article in a national magazine. This shortage, we are told, is "constantly becoming more critical." And the American Medical Association is "the one big obstacle in the path of Congressional efforts to meet that shortage with Federal aid to medical education."

Such incessant propaganda for socialized medicine, emanating in great part from the Federal Security Agency in Washington, has spread a false idea of the state of medical care in the United States.

Actually, since 1930 the number of doctors in the U.S.A. has been increasing proportionately faster than the general population. What is our situation compared to other lands? The United States has more doctors per total population than

any country in the world, excepting Israel, overcrowded with refugee doctors from Europe.

***What's Being Done to Get More Rural Physicians?***

MURPHY: Poor distribution is part of the shortage problem, but it is not the whole problem. Nor is it necessarily the easiest part to solve. While some of the wealthier metropolitan areas undoubtedly have more doctors than they need and many rural regions don't have enough, you cannot order city doctors into the country or coax them there by telling them about the birds and the trees. You must, as many Kansas towns have done in the last two years, add certain economic and professional elements to the atmosphere.

DE KRUIF: Medical progress in the past 15 years has made statistical estimates of a *national* doctor shortage meaningless. Yet here is a grim fact: Many cities are overdoctored; in some rural regions the shortage is severe.

But this problem can be met—and is being met—by local action. The continuing threat of socialized medicine has served one wholesome purpose. It has aroused state and local governments, civic and medical societies, to correct by local effort the deficiencies in our medical service.

As a result, we are going to have plenty of good modern doctors. By 1954, medical graduates will have increased by 22 per cent over 1940. By 1960, the year of the alarming shortage feared by Washington politicians, we'll have more doctors in proportion to population—and better ones—than we have today, and we already have more and better than any great nation has ever had before.

***Are Our Medical Schools Keeping Up With the Need?***

MURPHY: Doctors were relatively more numerous around the turn of the century than they are today. The U.S. average in 1909 was one physician for every 568 persons, as compared with one for every 760 in 1949. But the bald truth is that as recently as forty years ago America was suffering—and I use the term advisedly—from an appalling overproduction of undereducated and incompetent M.D.'s.

This unhealthy state of affairs was finally exposed by the Carnegie Foundation for the Advancement of Teaching. Abraham Flexner, of the foundation, and Dr. N. P. Colwell, of the A.M.A. Council on Medical Education, personally visited every one of the 155 medical schools then operating in the United States and Canada. The famous Flexner Report, published in 1910 at the conclusion of this study, listed each school by name, along with its merits and faults. The resulting publicity, plus the grading of schools on an A, B, C basis—

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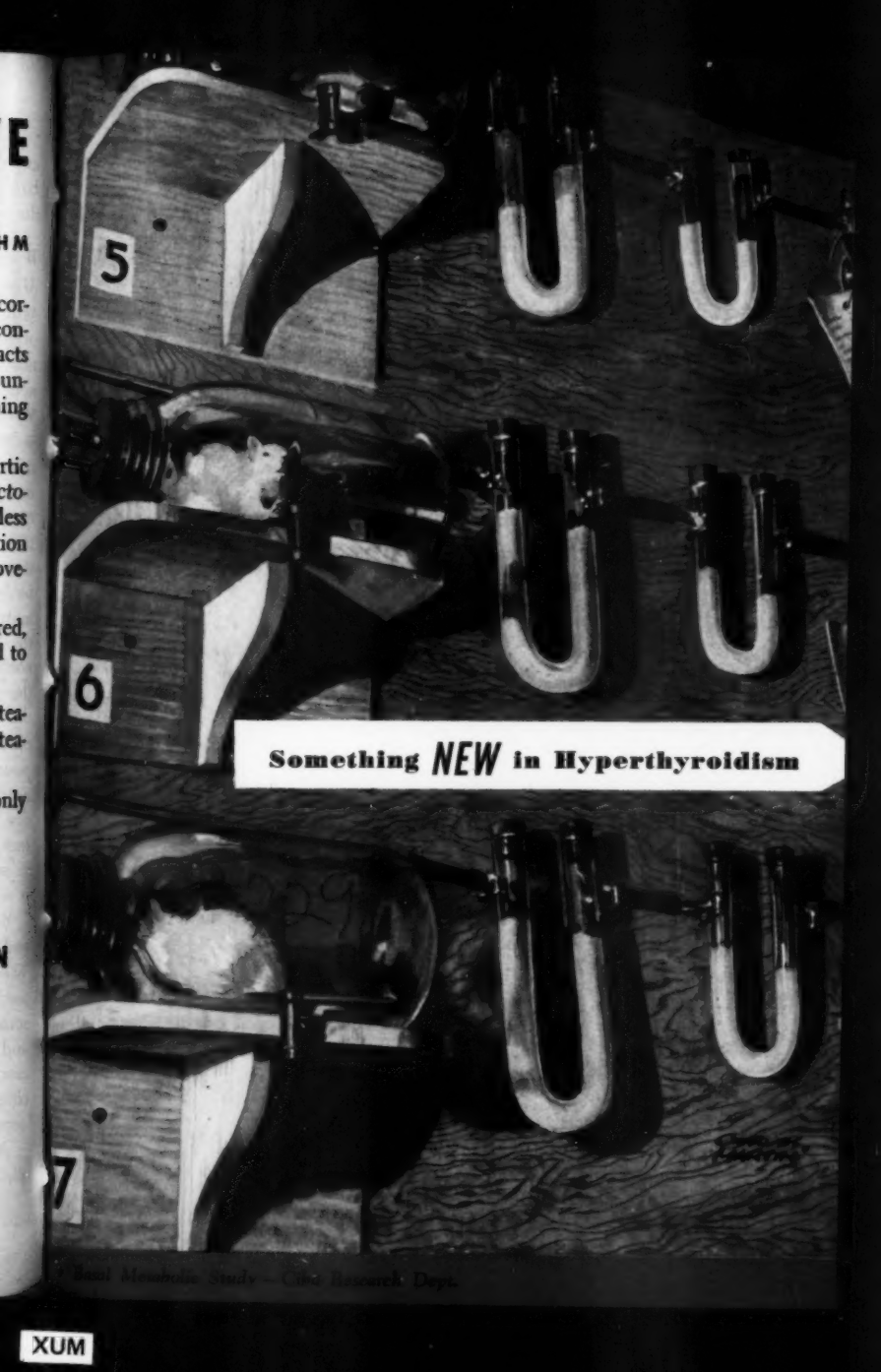
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Something NEW in Hyperthyroidism

which was continued until 1929—forced about half the schools to close their doors or merge with stronger institutions. During the period between 1906 and 1920 total enrollment shrank from 25,204 to 13,798.

That was really the beginning of our doctor shortage. The cutback in the production of inadequately trained physicians was, to be sure, good for the country. But some sections of the country were eventually left with very few indeed.

The nation's seventy-two full-status medical schools and seven basic-science schools are fully alive to the problem and have in the past ten years increased their enrollment by 5,000 to an all-time high of 26,193 students. About 6,000 will graduate this June, and the largest freshman class in history, 7,187, is now finishing its first year of studies.

This expanded enrollment is a significant move toward reducing the doctor shortage. But it is not enough. The approved medical schools, although increasing in number and output, have never quite been able to keep up with a growing population that has demanded not only better medical service but more of it because it is better. This, of course, is one reason the shortage forever pursues us.

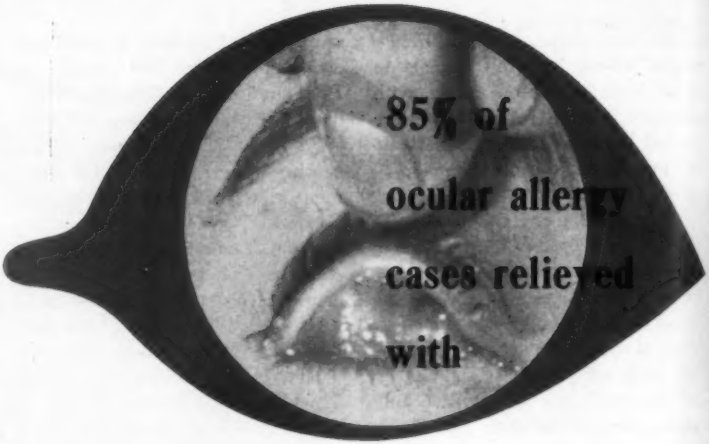
DE KRUIF: It's true that, by going back thirty years, statisticians can prove we have a practically stationary supply of doctors; in 1920 one doctor for every 729 people; in 1950 one for every 730. That looks bad, till you dig down for why. What were those doctors of the good old days? Many thousands of them graduated from diploma-mill medical schools where, on payment of a sum of money and without even seeing a sick person, a boy in a couple of years could get his M.D.

Between 1909 and 1920 the medical profession led a campaign which rid us of rotten medical colleges. Now modern schools—all Grade A—are graduating as many students as in the days when a quick M.D. could be bought for dollars. Our present institutions have increased their freshman medical classes during the past decade by an amount equivalent to the opening of fifteen new medical schools, reports Dr. Stockton Kimball, of the Association of American Medical Colleges.

### *How About Federal Aid For Medical Schools?*

MURPHY: The readiest source [of new funds] is the federal purse. An overwhelming majority of the schools, expressing themselves through the Association of American Medical Colleges, favor this method of obtaining needed help. But the schools' viewpoint has been flatly opposed by the A.M.A., which fears that the schools may become subject to Federal control.

Federal aid to medical education

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St. Clair and Bird likewise recommend Antistine Ophthalmic Solution used both as drops and packs for controlling local symptoms of conjunctivitis and dermatitis of the lids.[3]

Friedlaender and Friedlaender have found that it "produced symptomatic relief of burning and itching in cases of allergic conjunctivitis."[4]

Not only was Antistine Ophthalmic Solution effective in allergic conditions but even in chronic catarrhal conjunctivitis when "no allergic factors were manifest . . . symptomatic improvement was obtained in ten of thirteen cases."[1]

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1. Hurwitz, P.: Illinois M. J. 98:113 (Aug.) 1950.
2. Hurwitz, P.: Am. J. Opth. 31:1409 (Nov.) 1948
3. St. Clair, C. T. & Bird, B. W.: West Virginia M. J. 46:39 (Feb.) 1950.
4. Friedlaender, A. S. and Friedlaender, S.: Ann. of Allergy 6:23 (Jan.-Feb.) 1948.



Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, N. J.

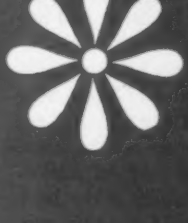
is now before Congress—for the third time. The Senate bill, which most deans favor, would help out the schools on an annual capitation basis—$500 per student already enrolled and $1000 per student to be added through expansion. Scholarships for needy students would be provided, and there is a $10,000,000 sum to be used to match funds raised by the schools for new construction, remodeling and equipment. The bill is an emergency measure, for five years. It does not permit the Government to subsidize any school for more than 40 per cent of its budget; the bill would be administered by the Surgeon General of the United States Public Health Service, with an advisory council of non-government doctors and educators.

The deans, of course, are no more anxious to sell their schools into bureaucratic control than is the A.M.A. But they think the measure is set up in such a way that the schools can be helped without being "kept." Medical schools have for several years been receiving large research grants from the Public Health Service and there has been no complaint, so far as I am aware, of Government interference with the work of the recipient schools. The schools see no reason to believe that the aid-to-education measure would present any more serious threat to academic independence.

DE KRUIF: From the Federal Security Agency comes a clamor that there will be a shortage by 1960 unless medical schools increase their output of doctors by 50 to 100 per cent.

But medical schools aren't mills into which the Federal Government can put dollars at one end and get highly trained doctors out the other. You can't expand medical schools by putting more chairs at the back of bigger rooms and having the professors talk a little louder. It takes ten years of grueling medical education to turn out a modern doctor. It takes one teacher—and a *good* one—to every fifteen or twenty students in the laboratory; in the clinics, one instructor for five students or ten. Where does the F.S.A. expect to get the competent medical

**"Yeah, a vaccination—'And where it won't show,' she says."**



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# Pabalate



professors that would be needed to double the medical schools' output in ten years?

Washington politicians have introduced a bill for Federal money to train doctors, and doctors representing some of the medical societies have fought this bill. That doesn't mean that they are against the sound expansion our medical schools need. Indeed, they are ready to go along with a law (like the Hill-Burton Act to help build hospitals) that will make Federal money available for new school facilities. But, having reason to dread bureaucratic control from Washington, they want such funds to be one-time grants, controlled locally.

By local enterprise the plight of doctorless communities everywhere can be alleviated without the inefficiency and wastefulness of Federal dictation. Those who are crying for Federal help would do well to remember these words of Dr. A. C. Sudan, famed general practitioner of Colorado: "When a dollar stays in your community it's still a dollar, but when it first goes to Washington it's diluted and trimmed, coming back to the community as a mighty small piece of change."

### *Can Voluntary Fund-Raising Do the Job?*

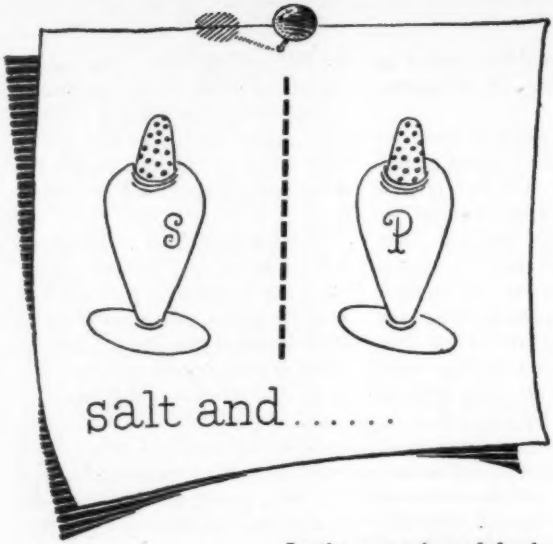
MURPHY: The A.M.A. has proposed an alternative to Government support which, if followed through, would go a long way toward solving the financial problem. The American Medical Education Foundation is suggesting that each practicing physician in the United States give $100 a year, earmarking his gift for the school of his choice if he wishes to.

The resulting fund of $20,000,000 a year, infused into the operating budgets of the nation's medical schools, would take care of most of their deficit problems. If a practicing physician can't give ten dollars a month to the school that educated him—at a loss to the school, because tuition covers only a small fraction of the cost—then he may be failing to recognize a moral obligation to his school and to his profession.

But moral obligations spread over the whole profession are not likely to raise enough money fast enough to pull the schools out of the hole and permit badly needed expansion.

DE KRUIF: [The physicians] have started to back doctor-training with their own money. In December 1950 the American Medical Association announced its contribution of $500,000 to the newly established American Medical Education Foundation. From doctors and other sources it is hoped that $5,000,000 will be raised this year, to be given without strings to our medical schools.

The untapped sources for voluntary support of medical schools are

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numerous. The pharmaceutical and chemical industries make millions from the new drugs used by our doctors. By high pay they're taking the cream of the young teaching investigators out of medical schools. That way they endanger the seed corn of medical education. When they lure bright men from the colleges they ought to be willing to contribute the money to put new ones back.

***How Will Military Needs Affect the Doctor Supply?***

MURPHY: The [physician shortage] will become more critical as additional thousands of doctors are called into uniform. For the second time in a decade the doctor supply has become a major national issue. It is a problem we have got to come to grips with unless we are to short-change one of the most vital departments of our defense, the health and strength and safety of our people.

Recently, Dr. Howard A. Rusk, chairman of the Health Resources Committee of the National Security Resources Board, told the medical-school deans that his committee had calculated the need of the country at 210,600 active physicians by 1954. This is 32,600 more than we have now, he said, and 22,000 more than present educational schedules will provide by that date. The committee's estimate, which I believe is on the high side, was based on the assumption that our troops by 1954 would number 5,000,000 and would require 18,500 of those doctors. Both these latter figures are subject to change in either direction, of course, but the over-all picture seems to make any talk of a doctor surplus highly unrealistic.

DE KRUIF: (did not go into this question).

***Don't New Medical Techniques Also Influence the Supply?***

DE KRUIF: We can't judge over-all need for doctors by simply counting doctors' noses. That's the yardstick used by Washington politicians. It's fishy. In World War II, 40 per cent of our doctors were called into the armed services, leaving 60 per cent of our M.D.'s to guard the lives of 91 per cent of the population. What happened? During the war the nation's health kept on improving, death rates sinking, life expectancy rising.

The fortunate fact is that one modern doctor can do what ten couldn't do at all thirty years ago. In those days doctors ran themselves ragged treating diphtheria; immunization has wiped out that drudgery. Inoculations and new wonder drugs have enormously cut down the hours doctors used to have to spend at bedsides of children sick with whooping cough, measles, mastoids, and other childhood ailments. Not long ago pneumonia meant weeks in hospital and day-and-night attendance by doc-

tors; antibiotics have reduced this killer to a minor illness.

It's fantastic how constantly evolving miracles are saving time for doctors. Penicillin was wonderful the way it cut down long-drawn-out and often futile treatment of blood poisoning, peritonitis, syphilis, and gonorrhea. But penicillin still had to be injected, often around the clock. Now come antibiotics like aureomycin, chloromycetin and terramycin. Quickly conquering these maladies, and also virus pneumonia, urinary, and other infections untouched by penicillin, they save doctors still more time because they're given by mouth by nurses or members of the family under the doctor's direction.

It has become ridiculous to measure medical care in terms of a doctor per so many patients. Our lives are now guarded by crews of nurses, X-ray and laboratory technicians of which the doctors are the captains. These crews multiply each doctor's hands and brains in every hospital and clinic, speeding up and sharpening diagnosis. Helping doctors to spot diseases earlier, they vastly cut down the time required to treat them.

MURPHY: (did not go into this question). END

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## Who Pays for Medical Research?

[*Continued from* 67]

percentagewise, the little fellows are doing even better. Collections of the American Heart Association are up 20 per cent, to better than $5 million so far in 1951. The Arthritis and Rheumatism Foundation, sparked by public interest in cortisone and ACTH, foresees an increase in this year's collections of 70 per cent.

The National Association for Mental Health, a merger of three previously competing organizations, expects cooperation to boost its take 500 per cent. Next year's goal: $3 million. The American Diabetes Association, which has operated on a paltry $100,000 a year, is reorganizing itself from a professional association into a voluntary health agency. It too is eyeing a seven-figure budget.

### *School, Hospital Funds*

Medical school outlays for research show a like rise, though most of the money comes from outside sources. For the current school year, American medical colleges have budgeted more than $26 million for research, an increase of about 10 per cent over 1950.

As for hospitals: Seventy of them in New York City recently reported they were spending about 3 per cent of their operating budgets on "medical education and research." If one-third of this can be credited to research alone, these New York hospitals are now spending about $1 million a year for this purpose.

Operating expenses of *all* the nation's voluntary hospitals are reported at about $1.8 billion a year. If roughly the same proportion here (as in New York City) goes for medical research, it means that our hospitals are contributing at least $10 to $15 million to this cause.

Why do they do it? For one thing, because of self-interest. As Dr. Martin R. Steinberg, director of New York's Mt. Sinai Hospital, points out: "The staff of a hospital with a well-developed research program is apt to provide a better level of care. Staff physicians begin to think of themselves as members of a more scientific body. Their pride is sharpened; the whole tone of the institution is lifted."

### *Doctor's Services*

Of the many indirect (and hence incalculable) investments in medical research, free service by physicians is probably the most important. Maybe you haven't stopped to think about it, but every time you take a careful history, make a comprehensive physical exam, dictate a complete report, and follow up the patient thereafter—even unto a competent autopsy—you're mak-


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ing a tangible contribution to medical research.

And did you ever pause to compute in dollars how much is being given every day in the services of staff physicians working on unpaid clinical research projects in the nation's hospitals?

### *Easy Money*

If your research interest happens to center on a disease that has captured public fear or fancy, your chance of getting money to follow up your project is greatly increased. Take polio, for example. The National Foundation for Infantile Paralysis has never yet had to turn down a legitimate research application for lack of funds.

Cancer research has also had much—but not enough—money. If you have an idea and the capacity for making a worth-while clinical study in this field, funds are yours for the asking. Nearly $160 million has gone into cancer research since 1938.

If heart disease is what you want to investigate, you'll have a little harder time getting money—but not so hard as a few years ago. Congress has grown partial to this field of research after seeing so many colleagues and constituents become heart disease victims.

Research money is tighter for several diseases that still rank among the top killers: tuberculosis, pneumonia, diabetes, and syphilis. Tuberculosis research will probably draw $1 million this year; the others much less. Nor does research get much financial nourishment in the prevention of three other leading death-dealers: prematurity, accidents, and suicide.

A glaring deficiency in available funds has long blighted research in psychiatry and mental health. This year, while nearly $3 million will be available, it still doesn't bulk very large when compared with the $500 million annual public charge for the upkeep of mental hospitals.

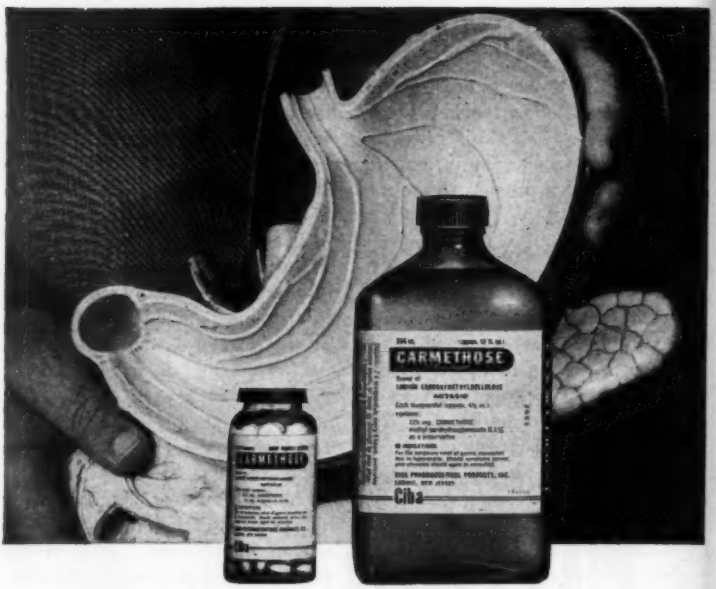
Classification of research funds by disease categories is, of course, not always possible—or even useful. The Curies were not looking for an agent (radium) that would be helpful in the treatment of cancer when they labored in their dirty shed with tons of pitchblende. Nor were the physicists engaged on the Manhattan Project seeking radioactive isotopes to treat goiter. Unexpected by-products are often the real dividends of research.

### *How Much Is Enough?*

With money for medical research streaming in from so many different sources, the question still remains: "Is it enough?"

If you go by the reports of the foundations and voluntary health agencies, the answer is "No!" But that doesn't quite settle it.

True, the nation's medical research outlay is comparatively small. It amounts to only three-tenths of 1 per cent of this year's defense budget, or about half our

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annual expenditure for hair tonics, shampoos, and other hair-care items. If more money were offered for medical research, it would undoubtedly find takers.

But how much could be expended fruitfully remains a moot point. The limiting factor today seems to be people—especially M.D.'s—at once trained, competent, and interested in research.

### *The Need Is Brains*

If money alone could buy research results, as some people fondly believe, the average span of human life would quickly be doubled. In fact, a president of the American Medical Association once predicted that with "a golden era of medical research" this goal could be attained.

But as Dr. T. Duckett Jones, an outstanding administrator of heart research programs, pointed out: "Basic or new knowledge cannot be predicted or directly purchased. Research remains costly, unpredictable, and time-consuming." By too much rigidity of plan and urgency for practical results, he said, we may actually impede the acquisition of those results.

The essential ingredient is, of course, men and women with the true research spirit. Says Dr. Louis N. Katz, president-elect of the American Heart Association, "The recruitment of new brains is our principal need."

What *is* this "research spirit?" You can't really pin it down in words. The work of successful researchers is its only positive definition.

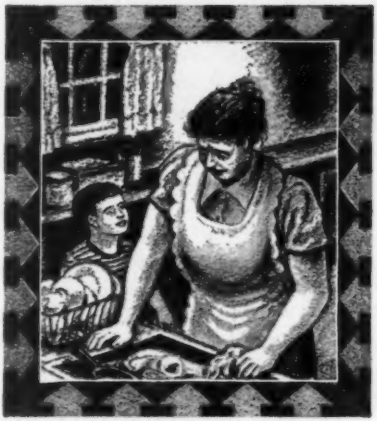
Dr. Alan Gregg of the Rockefeller Foundation offers a homely example. A friend of his, on a boat trip to China, lost his wrist watch, looked for it, and couldn't find it. His cabin boy overheard his tale of woe, called the other cabin boys together, and persuaded them to join him in making a new search (a *re*search, if you will). Not only did they find the missing watch; they also turned up two bracelets, a diamond ring, and a stickpin!

Greggs makes the crucial point that "research is a response to curiosity, not to need."

Probably every well-trained physician in the United States has some of the research spirit in him. If he could afford the time, he would do something about it. Many, of course, do. (Where would the bulk of current medical literature come from without their contributions?)

But medical research today is often a "specialty" outside the regular practice of medicine. Doctors who know their history can tell you that it used to be the other way around. Research in a wide range of sciences usually grew out of (and was paid for by) medical practice. A notable historical example was the case of William Gilbert, Queen Elizabeth's physician, who early explored the phenomena of magnetism and electricity. [*Turn page*]

# SUSPECTED!



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Not until late in the Nineteenth Century did medical research become "professionalized and institutionalized." The erection of the Pasteur Institute in Paris (with funds raised by popular subscription) marked the transition from research as an avocation to research as a business. And big business it has since become.

What can the practicing physician expect from this increasingly high-financed business of medical research? Here are some likely results:

1. *Increased efficiency.* Research improvements in diagnosis and treatment will help you serve more patients and serve them better. It's estimated that the American doctor's efficiency has been stepped up about a third in the last ten years alone.

2. *More reading and post-graduate study.* Unless research itself provides more efficient means of medical communication, you'll have to spend more time keeping up with the burgeoning number of research-born techniques.

3. *Greater attention to psychiatric and degenerative diseases.* You'll be less concerned with the acute infections, which research has already gone far toward controlling. You'll have more time to listen to psychogenic complaints. You'll see more heart and cancer cases, too, since Americans are getting older—thanks in part to past research.

4. *A better chance to do your own research.* If you have an acceptable idea and a place to work it out—your own office, perhaps, or a local hospital—you probably won't have much trouble getting money. Just file your application for funds with the appropriate Government agency, foundation, voluntary health association, or pharmaceutical company.

Some applications, of course, are turned down—but don't be afraid of an idea merely because it's unorthodox. Most of the advisory boards that pass on research applications have absorbed the wisdom in the story told by Simon Flexner when he was organizing the Rockefeller Institute for Medical Research.

He was asked by Professor Anton Dohrn of Naples, "Will you permit workers in your new institute to make fools of themselves?" For the moment, Flexner was silent. So Dohrn added, "Unless you do, you will make no great discoveries."

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## The Doctor Takes A Farm

[*Continued from* 55]

handled by the farmer and his sons.

"But that kind of farm is becoming extinct. The sons have gone to the city, the hired help into the factories. To compete for labor, the present-day farm has had to become big business itself—big acreages mass-producing in one or two specialty lines, like dairy farming or beef raising."

They were getting out into rolling, open country now, beyond the motels and drive-ins and highway furniture emporia. Farms were beginning to appear on either side. Hawkins was commenting on their size, pointing out that many of the larger ones were simply aggregations of small ones, as you could tell from the grouping of the buildings.

"That's been a big disadvantage in the evolution from the small farm to the big farm, because each of the component small farms still has its own cluster of buildings. It doesn't make for efficient, centralized operation. Too much time and energy are lost running from one farm to another. Besides, the buildings themselves aren't designed for large-scale farming; and most will be the wrong type for the single operation you're concentrating on. This kind of Topsy-grown farm is something to avoid when you buy."

"Well, that's good to know," said Dr. Gormley, "although I wasn't thinking of getting into farming on a really large scale. What I want is a nice place that will be a hobby for me and a hedge against inflation."

"Which means," said Hawkins, "that it has to earn a profit. It's not going to be a hedge against anything if it's a money-loser. A lot of business and professional men go out and buy a farm for investment. Then, when it turns out to be a lemon, they console themselves with the thought that anyhow, they've got a hedge against inflation.

"Of course, that's nonsense. They might just as well buy a few truck loads of fallow dirt and store it in their cellar. Land, just because it's land, isn't an inflation hedge. It has to be useful, profitable land."

Furthermore, he continued, wringing a profit from farming was a neater trick than most city folk realized. To begin with, a farmer didn't set his own prices, the way a doctor could set his fees. Rather, they were set for him by those old school chums, supply and demand, with a complicating assist from the Government. Nor did high food prices necessarily mean a bonanza for the farmer. With milk at 24 cents a quart, the farmer got only 10 or 11 cents. With beef at $1 a

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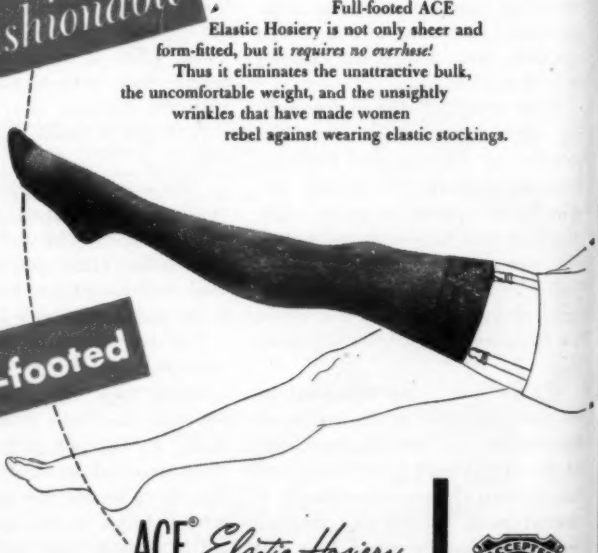

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pound, he got maybe 30 or 40 cents—if his beef was top grade.

"The middleman takes the lion's share," said Hawkins, "and the farmer's spread is always a small one. When he has a big crop, prices are down. When prices are up, he has a poor crop. I don't know of any business where the profits, in general, are so small in relation to the risks."

Take the weather, he said. Too much rain was bad; so was too little rain. The only reason a farmer didn't worry morning, noon, and night about the rainfall was that he had to allow time to worry about livestock diseases.

"In a poultry operation, diarrhea can kill off 30 to 60 per cent of the flock in a matter of weeks. With cattle, there's trichomoniasis, vibriosis, and brucellosis, none of which the veterinarians understand too well as yet. The first two keep you from getting a live calf, the only source of income in beef operations. Brucellosis also causes abortion and cuts a dairy cow's milk output 40 to 50 per cent. Treatment is expensive and the animal is out of production for at least six months. What's more, from then on it's hard to sell any of the herd, because it can't be certified as free of the disease."

"With all those hazards," said the doctor, "it sounds as though the odds are stacked against success."

"The odds are very close. You need every break you can get. The two important things at the start are *the price* you pay for your farm and *what you get* for that price. If you're paying a full price—and most farms today are priced right up to the hilt—you have to be sure you're getting a well-balanced farm, irrespective of size."

The doctor was beginning to feel hep. "You mean the barn and the pasturage have to be the right size for each other?"

"I mean *everything* has to be right in relation to everything else—land, buildings, equipment, labor, and livestock. You'll see when we get to looking over some of these places."

Presently they came into a village with a quaint church and a small shopping center around a green. They parked and went into a real estate office, whose proprietor Hawkins knew. Introductions were made and the three men sat down around a desk. Hawkins explained his client's needs, and the agent got out maps and photographs. Only

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one place looked at all promising—a 160-acre farm at $36,500, asking. The agent offered to drive them out, but Hawkins and the doctor had him furnish directions instead.

As they got under way again, Hawkins talked more about farming. It fell, he said, into two main categories: intensive and extensive.

"An intensive type of operation would be truck farming or poultry, or perhaps an apple orchard. You don't need much land, but you must use it intensively, especially in truck farming. The returns, per acre and per dollar invested, are higher; but close, expert supervision is needed, almost minute by minute. Lots of scheduling and planning, as in a highly geared manufacturing plant."

The Gormley brow wrinkled. "Look, that's not really what I'm after. I just want . . . "

"Something you won't have to run with a stop-watch?"

"Well, yes."

"Beef cattle or dairying, in other words. Or a crop operation, though most farms here in the East can't compete with the flat-country, cheap-labor grain operations of the Midwest. What we do have, though, is good rainfall, producing the kind of hay and pasture you need for successful livestock farming."

"That would be an extensive type of operation?"

Hawkins nodded. "You need more land, but it needn't be of the highest type. This place we're going to see is priced at about $228 an acre, which is neither high nor low. Prices are apt to run anywhere from $50 to $350 an acre, hereabouts."

### *What Price to Expect*

"So $228 is pretty fair, you think?"

"That depends on the land itself, and what's on it. Sometimes even $50 an acre is highway robbery. As a rule, it's better to pay more for your land at the outset, and get good land, than to buy cheap and then sink a fortune in fertilizer and such, trying to make it pay. For example, it costs no more to produce 100 bushels of corn per acre on good land than it does to produce sixty bushels on mediocre land. And that 66 per cent greater production on the good land boosts your acreage profits 400 to 500 per cent."

"What makes for good land?" the doctor wanted to know.

"That depends on what you're going to grow. One thing you always need is top soil, which means you have to keep an eye out for the effects of sheet erosion. Then the sub-soil has to be right for your particular type of operation. Also, if the previous owner hasn't rotated his crops, the land may have been mined of its nutrients. You're liable to find too much acidity, measured in terms of what we call the pH factor."

[*Turn page*]

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"Hydrogen potential," said Hawkins, "the concentration of hydrogen ions in the soil. We express it in terms of a logarithmic scale, on which a reciprocal of 7.0 is neutral."

"Come again?"

"Well, it's pretty technical," Hawkins said, "and it's one of the things you're paying *me* to worry about. Just remember that the lower the pH, the higher the acidity. Most crops do best in a soil just below pH neutral, say around 6.0. So if your soil test shows about 5.2, it probably means that you're going to have to put down about two tons of ground limestone per acre. That'll run you maybe $18 an acre. There's also a delay of some months before you begin to get the full benefit of the lime."

"I begin to perceive," said Dr. Gormley, with a wry grin, "that farming is a complicated business."

"I trust you also perceive that we're hitting only a few of the high spots."

"I'm afraid I do," he sighed. "Now I know what gives farmers that hard-bitten look."

But his spirits took a turn for the better when they hove in sight of the property. Even Hawkins' first impression seemed favorable. The place was on a good macadam side road, he noted, and not too far from the village, with its shopping and school facilities. There were electric and phone wires leading into it; and besides the main house, there was a cottage.

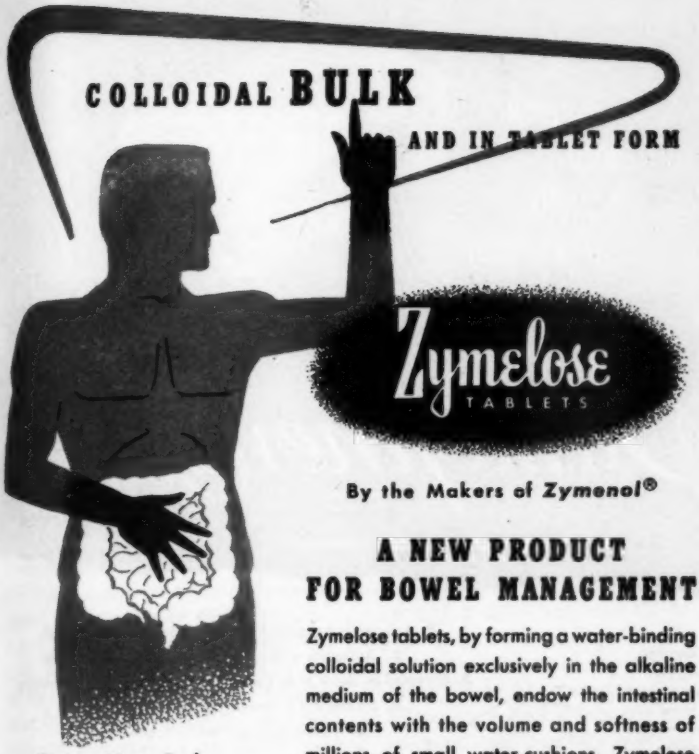
Hawkins looked for out-houses and remarked that apparently both dwellings had inside plumbing. Such things, along with central heating and like conveniences, he said, were important in attracting the right type of hired help—preferably one or two family men. The cottage, he pointed out, would facilitate a two-man operation, rather than a one-man, if the doctor chose.

Each had its advantages. The two-man set-up cost more but provided insurance against such exigencies as a tenant's being laid low by sickness. Also, it was a partial safeguard against dishonesty in the management of the farm.

### *Tenant Headaches*

"This whole question of getting along with tenants is a psychological study in itself," Hawkins explained. "You've got to know what peccadilloes to overlook and what not to. Even if a man's honest as the day is long, he may simply take a dislike to you, in which case he can cross you up plenty. The city slicker always starts out with two strikes on him, and the burden of establishing the right kind of relationship is strictly up to him."

The farm in question, owned by a New York attorney, was being operated for a little truck produce, along with eggs, corn, and alfalfa. Fifteen or twenty head of cattle were grazing in a nearby field. The

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owner was moving to another part of the country, the agent had said. The tenant farmer, friendly and apparently intelligent, occupied the cottage with his family; the main house stood empty. He showed the visitors through each of the buildings in turn.

Both appeared to be in good repair and were freshly painted. Hawkins had a close look at the siding and roofs, then examined the sills for evidence of termites and dry rot. The interiors seemed in fair shape. The doctor was quite taken with the main house, with its fireplaces, old-fashioned central hall, and long veranda that looked out through fragrant lilacs across a sweep of fields to blue hills in the distance.

Inspection of the barn and shed buildings came next. Here Hawkins spent quite a bit of time, measuring the stanchions and pacing off distances and jotting things down in his notebook. The doctor noticed that he was also making the same sort of structural examination he had with the house and cottage.

### *Checking the Extras*

Afterwards, when they had left the tenant and set out to explore the farm itself, Hawkins explained that you were generally better off buying a going concern than a bare farm that had to be equipped from scratch. "You usually get more for your dollar," he said.

"Now, this place is somewhere in between. You've got about half the herd you'll want, and most of the equipment. That hay baler by the barn, for instance, would cost you about $2,200 new. You probably wouldn't have wanted to invest in one if it didn't come with the place, because you'll be running only about forty or fifty acres of hay and straw. But it'll be good to have, as long as it's here, and you can do some custom work for the neighbors.

"Assuming the cattle are all right—and I'll get a vet out to check them—you're off to a good start. They're Holsteins, and it's a Holstein barn. Bigger stanchions than you'd use for Jerseys."

"You mean a barn should be designed for the breed of cattle?"

"Right. Some buyers, who don't know any better, will even buy a place with a dairy barn and try to convert it to beef raising. They'll end up with a $20,000 barn and no chance of profitable operation. Better if they'd burned it and put up a pole-type building for three or four thousand dollars. There's not enough profit per animal in beef to warrant much investment in the barn."

As they walked and talked, Hawkins was gathering up soil samples and putting them in a compartmented bag he'd brought along for the purpose. Now and then he stopped to examine whatever was growing underfoot or to have a look at the fences. By the time they

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got back to the house, the sun was going down.

"I've been going on the assumption that you like the place," Hawkins said.

"Yes, and I'm hoping *you* will."

"Well, I'll have to run out here again next week and have a talk with the county agent and some of the neighbors. I also want a longer chat with the tenant. What did you think of him?"

"Seemed okay to me."

"He did to me, too. But I'll check around on him a little. He says he's been getting $150 a month and keep, plus 10 per cent of the profits, which isn't a bad arrangement. It's a good idea, if possible, to keep your personnel intact when you take over a place."

As they rode back to the city, the doctor tried to get Hawkins to commit himself further on whether the place was a good buy. But the consultant wasn't yet ready to say.

"You'll have a report within ten days. That'll tell the whole story."

The report arrived in a week. It was a fairly voluminous document, including a detailed map of the property. Its highlights:

¶ Soil slightly acid. Estimated cost of recommended treatment of 120 acres: $1,100.

¶ Some 3,000 feet of new fencing needed. Cost, in materials and labor, for a medium-grade of fencing: $3,750.

¶ Forty acres of pasture require re-seeding. Estimated cost, for seed, fertilizer, labor, and machinery time: $1,200. Cost of temporary crops till pasture's ready for light grazing five months hence: $800.

¶ Field and milking equipment in generally good condition. Sale of combine recommended.

¶ All buildings structurally sound and in good repair. Milk room of barn fails to meet requirements of local board of health. Cost of renovation: $1,200.

¶ Probable cost of another twenty head of cattle, to bring herd up to optimum proportions: $10,000.

¶ Estimated realization value of chickens, combine, other assets not needed for the new operation: $960.

All and all, the report concluded, it was the firm's opinion that the subject property, at $228 per acre, was overvalued by about 10 per cent. [*Turn page*]


**"The next stronger one would be a dog."**

His hopes all but dashed, the doctor got Hawkins on the phone.

"No soap, eh?" he said.

"That depends," said Hawkins. "Do you really like the place?"

"Yes, but not enough to get stuck. If it's priced out of line . . . "

"That's their *asking* price. You could make them an offer."

The Gormley eye brightened. "How much?"

"Oh, maybe $31,000. If they'll meet you at $33,000, you wouldn't be too badly off."

"Good. Now, there were a couple things in the report I didn't quite understand . . . "

### *Tax Saving*

They got together the next day, and Hawkins explained the fine points. He also talked some about taxes. If the doctor were to lose money the first few years, while rounding the farm into shape and building up its ultimate value, these losses would be deductible for tax purposes. If he were in the 50 per cent bracket, for instance, they would cut his taxes considerably. Then, if he were some day to sell the farm at a fat capital gain, this would be taxed at only 25 per cent. In effect, the Government would be bearing half the losses it took him to achieve his ultimate gain.

"Or suppose you get into breeding operations," said Hawkins. "You can take 100 per cent deduction on your losses while you're developing a good strain of breeding stock, then pay only a 25 per cent tax on later profits according to current interpretation of the tax law."

But for the moment, the doctor was more interested in profits than losses. "As I see it," he said, "the place is going to cost me about $50,000, all told, with maybe another $10,000 tied up in working capital. Once I get underway, what kind of return can I expect?"

Hawkins shrugged. "My guess would be that most farms in the East don't show better than 2 or 3 per cent, on the average. Some earn maybe 5 per cent. There are plenty of better investments."

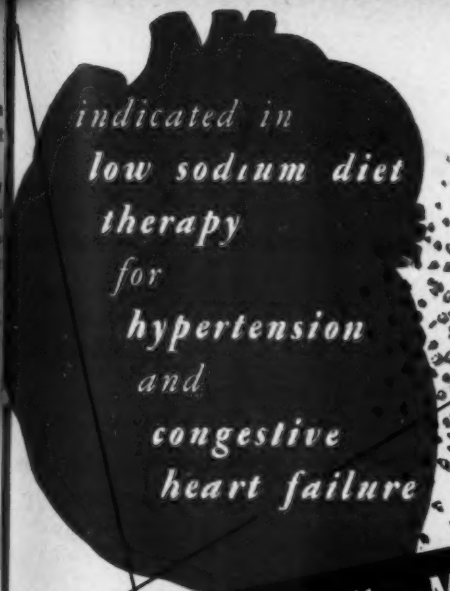
"Hmm." The doctor was doing some figuring. "And how much would you people want to run it for me, saving me all the headaches?"

A pause. Hawkins considered.

"Well, we'd have to think that over. Offhand, I'd say probably from $75 to $100 a month. This would be a pretty small operation for us."

The doctor nodded. Even at the higher figure, he thought, it would probably be worth it. In any case, he'd decided, he was going to have himself a farm—if the owner would come down a few thousand.

Back at his office that afternoon Dr. Gormley wired the agent his offer. As he hung up the phone, he found himself humming a tune that hadn't run through his head since boyhood days. He couldn't quite recall the name of it. Something about a farmer in the dell. END

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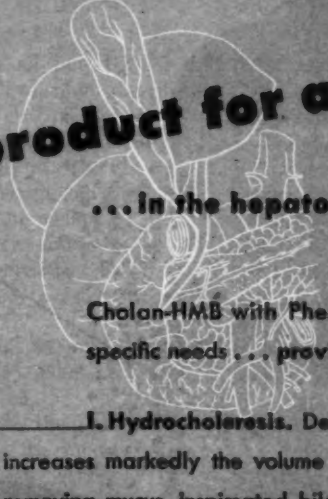

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## Do We Need a Federal Medical Academy?

[*Continued from* 63]

cilities and faculty. Thus the plan would not seem quite so expedient as we have been led to believe.

Then too, the proposed method of selecting students raises some serious questions. Would a system of selection controlled by Federal officeholders insure choices based on merit alone? Would the academy, against stiff competition from established schools, really attract the best qualified applicants?

It's my belief that the best-qualified applicants would not be enticed into an academy where the prospect was six or eight years' regimented training followed by five years' captivity. Such an academy would appeal only to men interested primarily in security, a regular routine, and a retirement pension.

The specialized training proposed would have serious limitations also. Too early specialization in aviation medicine, for example, might seriously impair the sound general training every doctor needs. Likewise, the problems of the submarine specialist bear little relation to those of the public health man. How, then, would the academy give students a thorough medical grounding and still prepare them for widely divergent specialties?

Civilian planners have foreseen clearly the need for certain specialists. The Olsen report of the Association of American Medical Colleges, for example, already has recommended an additional 278 hours of instruction in such fields as aviation and civil defense.

If the need for specialists is more immediate than that, why doesn't the Government now offer inducements that would attract young doctors to the special fields of military and public health medicine? Basic training in medicine could very well be left up to the existing medical schools and, if the future were attractive enough, many physicians would enter Government medicine on graduation.

Even West Point and Annapolis do not undertake such an ambitious program as that suggested by the medical academy proponents. Their graduates, after a militarized undergraduate course, are sent to other training centers—often civilian universities—for specialized training.

All of which points up the essential fallacy of the medical academy idea. There is no real proof that our existing medical schools are unable to meet the national demand for doctors. And there is no real proof that the academy structure would be suitable for the study of medicine. It would be as logical, in my opinion, to set up academies for statisticians and lawyers. END

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MEDICAMENTA VERA

# The Newsvane

## V.A. Consultant Quits, Blasting Boss

"Bureaucratic meddling" in the Veterans Administration has been cited by Dr. Howard D. Fabing of Cincinnati in explanation of his recent resignation from his V.A. post.

Dr. Fabing served as V.A. consultant for the Washington area. At the time he quit the job, he minced no words in criticizing Veterans Administrator Carl R. Gray. Specifically, he attacked the tactics by which Gray, he said, had assumed control of V.A. hospitals and by-passed the former medical director, Dr. Paul B. Magnuson.

## Prepay Plan Rips Income Ceiling Off

More than 6,500 doctors have signed up as participating physicians in a new plan by which Group Health Insurance of New York City pays all medical-surgical costs for hospitalized members regardless of their income.

Instead of using an income ceiling, GHI draws the line another way: The paid-in-full plan applies only when members accept hospital facilities no more expensive than a semi-private room.

If a patient insists on a private room, indicating an income adequate for extras, GHI pays scheduled fees only. The doctor is then free to bill the patient for an amount above that paid him by the insurance plan.

Formerly, GHI paid all doctor bills for hospitalized members with yearly incomes under $3,000. Blue Shield's comparable income ceiling is $4,000.

Monthly membership premiums are now higher across the board for GHI than for Blue Shield:

| | GHI Premium | Excess Over Blue Shield |
|---|---|---|
| Single | $ .90 | 18¢ |
| Couple | 2.10 | 46¢ |
| Family | 3.15 | 19¢ |

GHI is a nine-year-old outgrowth of Group Health Cooperative in Washington, D.C. But it has changed from a co-op to a corporation and now operates independently. County medical societies of five New York City boroughs have approved its new paid-in-full plan.

## Divorces Dianetics Head As 'Mentally Ill'

A divorce suit has been filed against L. Ron Hubbard, 40, founder of the dianetics health cult, by his second

wife, Mrs. Sara Northrup Hubbard, 25. In her suit she charges that the maestro of mental health is himself mentally ill. She quotes "competent medical advisers" as stating that he should be placed under "psychiatric observation" for "paranoid schizophrenia."

One half of his split personality, she says, has built up his Dianetics Research Foundation, which last year "did more than $1 million business." Meanwhile, the other half has been inflicting "systematic torture" on her, she charges, beating and strangling her and suggesting that she kill herself to spare him the scandal of a divorce.

Mrs. Hubbard also questions the legality of their marriage in 1946. She has learned that he did not divorce a previous wife until 1947. In view of this, she indicates that she will settle for an annulment instead of a divorce, plus $500,000 to console her for wasting "the golden years of a woman's life."

## Interest Revived In M.D. Pension Plans

Signs of rising interest in pension plans for professional people will cheer the average physician, who has long complained that he is not given a reasonable tax break in setting aside funds for his retirement.

Current conversation pieces are these two courses of action which would end discrimination against the professional man and put him on a par with the industrial executive:

1. An amendment to the pension trust provision in the tax law, that would permit professional men to formulate pension plans, the costs of which would be deductible in computing current income tax but subject to taxes when the trust became effective later.

2. An individual retirement plan whereby a professional man with earned income would be permitted to set aside a fixed proportion of it each year. Funds, if invested in certain non-negotiable government bonds, would be exempt from current taxes but subject to taxation when cashed after maturity.

Both these ideas, which originated with the American Bar Association four years ago, would require Congressional action.

## M.D.'s Seek to Whittle Malpractice Premiums

Malpractice insurance costs will get some strenuous reducing treatments if the District of Columbia medical society has its way.

Early this year the society planned a course of action to bring about a cut in premiums on its group professional liability insurance. But before the plans could get off paper, came a setback:

The insurance company announced that premiums, far from dropping, would jump 33 per cent as of April 1. The $38 base rate for


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$5,000/$15,000 coverage leaped to $50, and premiums for additional or special coverage went up correspondingly.

Asked why, the insurance company cited an "unfavorable loss ratio" for 1950. Moreover, it implied that doctors had brought the increases upon themselves. It traced fully one-fourth of the year's malpractice suits to derogatory remarks made about physicians (in the presence of their patients or former patients) by other physicians.

Quick to take a hint, the D.C. society is now working for lower premiums by

1. Furnishing expert witnesses to fight some of the malpractice suits already filed, and
2. Pushing an educational program to alert members against the slips that give rise to malpractice suits in the first place.

## Penicillin Bait Catches V.D. Statistics

Private physicians have been quick to accept public health department offers of free penicillin for any syphilis cases reported. Result: a more complete picture of the incidence of the disease, says Dr. Walter Clarke, executive director of the American Social Hygiene Association.

In Petersburg, Va., for example, the free-penicillin deal has upped reporting of syphilis about 650 per cent, Dr. Clarke comments. Instead of five or six cases a month in this city of 30,600, doctors are now reporting forty-five or more.

## V.A. Shields Its M.D.'s From Army Poaching

Efforts of the V.A. to keep its medical personnel from being "hijacked" into the armed forces have been summarized for Congress and read into the Congressional Record in a statement from Carl R. Gray, Veterans Administrator. Already, he reports, since the start of the Korean war, the armed forces have snatched away about 400 V.A. physicians and nearly as many nurses.

But this, he fears, is only the beginning. Of the V.A.'s 4,000 full-time doctors, about 50 per cent are reserve officers and subject to call.

"The situation isn't as desperate as it was in early 1943," Mr. Gray admits, "when the loss of doctors threatened to wreck the entire V.A. medical set-up. But it is gradually moving in that direction."

The V.A. has been erecting paper barricades to protect its beleaguered medical men:

1. It's publicizing its rights under the amended Servicemen's Readjustment Act, which gives the V.A. priority "equal to that of any other agency in the manpower pool."

2. It has set up a manpower board to obtain delays when a reserve doctor is called up. But so far it has been "only moderately suc-

# PREMENSTRUAL TENSION...

## An Entity and Its Management

### —Abstract*—

***THE CONDITION...***

The syndrome of premenstrual tension—depression, headache, breast tenderness, bloating, edema, thigh pain, irritability and lassitude—is said to occur in possibly 40% of menstruating women. Its cause is speculative, although fluid retention related to pituitary activity explains the symptoms and findings.

***TREATMENT...***

Because of the anti-pitressin diuretic effect and analgesic action of M-Minus 4, the author employed this agent in a series of 153 patients with premenstrual tension. Of the group, 41 had an associated dysmenorrhea.

***EFFECTIVENESS...***

Results were uniformly good, with at least some relief in all cases. The approach is described by the author as rational, combining ease of administration, economy and safety with clinical effectiveness. Of the 41 patients with concomitant dysmenorrhea, 31 were relieved with M-Minus 4.

*"Theory and Rationale in the Treatment of Premenstrual Tension and Dysmenorrhea," Vainder, Milton: Industrial Medicine and Surgery, *20*:199-201 (April) 1951.

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cessful," Mr. Gray admits ruefully; the best it can do is to get a six-month respite.

3. Congresswoman Edith N. Rogers (R., Mass.) has started a bill through Congress to freeze doctors in their V.A. jobs for the duration.

4. The V.A. has conferred with the National Security Resources Board about its medical manpower problem.

But these are measures for temporary relief only, Mr. Gray acknowledges. He sees no source from which a real supply of additional doctors can come quickly to give both the armed forces and the civilian departments an adequate number. So he hopes that some of the temporary measures will take effect and save the V.A. from a repetition of its near-disaster in 1942-43.

## New TV, Radio Series For Medical Societies

Medical societies can "take to TV" with a new production packet prepared by the AMA. Now available are twelve 15-minute shows on cancer prevention, high blood pressure, school health, first aid, and other popular subjects. Scripts carry full instructions for TV shows with small casts and few props.

For medical societies that do not have access to a TV outlet, electrical transcriptions on socio-economic phases of medicine have been released for radio use. Entitled "Main Street Medicine," the 13-program series deals with the achievements of local communities in providing better medical care.

## New Tax Bill May Bar Hobby Losses

If you're a gentleman farmer, used to charging off farm losses against regular income from practice and other sources, chances are that Uncle Sam is going to have bad news for you. This is one of the "loopholes" that the House Ways and Means Committee voted to plug in the new tax bill.

Also on the committee's approved list is a plan to pinch off taxes on dividends, interest, and royalties—at the source. By withholding such items before you get them, the Treasury hopes to stymie a lot of people who "forget" to put such income on their tax returns.

Tighter rules on "hobby" losses will mean this: To get by with such deductions, the taxpayer will have to prove that the sideline business "was conducted primarily for profit and not for his personal gratification." Otherwise, the losses won't be deductible where there's been a net loss for three of the previous five years.

The withholding plan for dividends, interest, and such items as royalties on books and patents will probably work out this way: Banks, corporations, and the Federal Gov-

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ernment will subtract a flat 20 per cent of such payments, mail the rest to you.

Say you have $1,000 coming to you. You get a check for $800, and the rest goes to the U.S. Treasury with a withholding tax return like the one used for wages. When March 15 rolls around, you take a credit for the tax withheld, figure out whether you owe more or whether the Treasury owes you something.

This new system of collecting ahead of time would apply even to savings bank interest and savings bonds. But interest on state and municipal bonds is not taxed. Nor is interest paid by an individual.

## Gives Clue to Extent of Catastrophic Illness

How common are "catastrophic" sickness costs? A hint of the answer comes from the Liberty Mutual Insurance Company.

Reporting on one year's experience with a group of 2,500 men with annual incomes of $5,000-plus, it reveals that

¶ Serious illness costing an average of more than $100 a month struck 2 per cent.

¶ Medical bills of four men exceeded $5,000 apiece.

Wives of these men, the company finds, incurred even greater expense. Over a seven-month period, for instance:

¶ Medical expenses averaging about $100 a month were incurred by 6 per cent.

¶ One woman received medical attention costing $7,800, or more than $1,000 a month.

## Congress Ties Strings To Ewing Money

Federal Security Administrator Oscar Ewing saw some ominous handwriting on the wall in Congress if he watched the progress of the last FSA appropriations bill through the House. Two amendments hitched to the bill, their makers said, were aimed at removing a little of the security from the FSA; they restricted the money and the propaganda permitted to Mr. Ewing and his underlings.

Specifically, Congressman Lawrence H. Smith (R., Wis.) offered an amendment banning use of FSA funds "for publicity or propaganda purposes not heretofore authorized by the Congress."

At the same time Congressman John B. Williams (D., Miss.) offered an amendment to trim $229,000 from appropriations of the Office of the Administrator. The FSA, Representative Williams hinted, is top-heavy with administration. Pointing out that private industry needs one personnel employe for about 150 operating employes, he reported that the FSA ratio is 1:20.

He reminded fellow Congressmen that Administrator Ewing had already spent "thousands of Gov-

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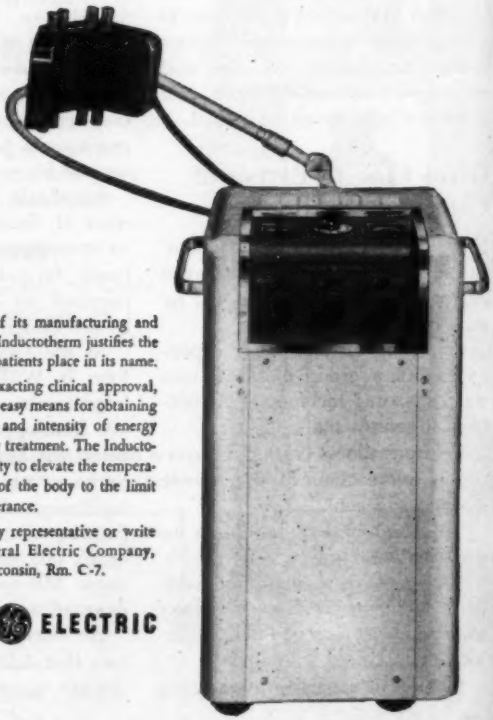

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ernment dollars in visiting England and other countries where socialized medicine is practiced . . . [and] is most pointedly in favor of a program of socialized medicine in this country."

## Rx Writing Last Year Hit Record High

Doctors wrote more prescriptions last year than ever before in history, says Drug Topics, the druggists' newspaper. Its latest prescription census shows that medical men scribbled out a total of 389,178,886 masterpieces of illegibility in 1950, the most yet recorded.

That's an increase of nearly 3 per cent over 1949 prescription production. Compared with the 1945 output, it amounts to a hike of 92 per cent.

Why should the prescription business have gained altitude so rapidly when total drug store sales went up only 20 per cent in the same period? Drug Topics sniffs out a connection between the high-flying prescription figures and the number of new pharmaceuticals entering the market, saying the two soar side by side. As prescriptions were making their five-year rise of 92 per cent, new drug products increased 100 per cent.

Patients paid a prescription bill last year of $648,794,713, or 11 per cent more than in the preceding year. That makes the average Rx price tag for 1950 read $1.67. In 1949 the average was $1.54, but that was before the last couple of new antibiotics.

The one down droop in the upturning prescription trend is the ratio of refills. It lagged last year, for the first time since 1942. Drug Topics ties this to the inhibiting effect of the Food and Drug Administration campaign against unauthorized refills.

## Sees End of Sliding Scale Of Fees

The sliding scale of fees may have to go if medicine is to solve some of the health insurance problems that challenge it today. This is Dr. Howard K. Petry's warning to members of the Pennsylvania medical society.

To quiet criticisms of voluntary health insurance, he urges "more aggressive support" of insurance programs and "greater uniformity of fees, so that more comprehensive and broadly applicable insurance policies may be written."

Anyway, justification for the sliding scale is gradually disappearing, he observes, along with income extremes among patients.

"Medical men were the original income-tax collectors. We took from the rich; we gave to the poor. But Uncle Sam has taken over our job and does it so effectively that the rich are becoming a memory only." There goes Justification No. 1.

As for Justification No. 2: "Insur-

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ance, veteran, and social programs are eliminating large groups of indigents," he says.

Result: "Our two greatest arguments for a sliding scale of fees are being whittled down."

## Mixed Reactions Greet Revival of EMIC Idea

Plans for a counterpart of World War II's Emergency Maternal and Infant Care program, recently put before Congress in two different bills, have met with bitter opposition, urgent support, and resigned acceptance.

From Minnesota, hurrahs: The State Legislature in a joint resolution has urged Congress to rush EMIC immediately.

From Michigan, howls: "Those who would combat socialism must make up their minds to work awfully hard, and soon," says the state medical society journal, rallying opposition. The journal warns against getting "entangled" with a repetition of the old EMIC. "The Government paid the bill, inadequately, and controlled the service with restrictions and regulations 'superadequately.' Do we want that again? . . . We contend a more just scheme could be evolved."

From hospital circles, resignation: "The significant point is that such benefits are likely to be allowed," says George Bugbee, executive director of the American Hospital Association, writing in the magazine Hospitals. Already, he points out, obstetrical and infant care accounts for about 60 per cent of all the benefits being given servicemen's dependents by doctors with the armed services.

In case EMIC in any form should rise again, he stresses the need of "a wise program." He suggests: "If the Federal Government is to provide hospital and medical benefits for dependents of servicemen, it might well consider the purchase of a hospital and medical care contract similar to that now available to automobile and steel workers. Such a contract could be available to military personnel of higher pay grades on a part-time or full-time payment basis. Such a contract would minimize use of military hospitals, offer excellent protection for dependents in home communities, and permit selection of the desired type of care by dependents located near military installations."

## Half-Size Phone Booth Can Serve Patients

Physicians seeking to provide that "extra" in service to patients may soon be looking into the new half-size, doorless telephone booth. Known as the Acousti-Booth, the device can be placed on a reception desk or waiting room table, or attached to the wall.

The doorless booth is slightly deeper than conventional models but only half as high. It's lined with

***a most significant advance***

# TROMEXAN

T. M.

*ethyl acetate*

## *new, safer, oral anticoagulant*

Throughout the exhaustive studies on TROMEXAN, involving many hundreds of cases, this new anticoagulant has proved singularly free from the dangers of hemorrhagic complication. Other advantageous clinical features of TROMEXAN are:

1 ***more rapid therapeutic response***
(therapeutic prothrombin level in 18-24 hours);

2 ***smooth, even maintenance of prothrombin level***
within therapeutic limits;

3 ***more rapid return to normal***
(24-48 hours) after cessation of administration.

In medical and surgical practice . . . as a prophylactic as well as a therapeutic agent . . . TROMEXAN extends the scope of anticoagulant treatment by reducing its hazards.

***Detailed Brochure Sent on Request.***

TROMEXAN (brand of ethyl biscoumacetate): available as uncoated scored tablets, 300 mg., bottles of 50 and 250.

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sound-absorbing material that keeps out exterior noises and soaks up reflections of the speaker's voice.

## Says Secretaries Could Rescue British G.P.'s

Grants to help busy British G.P.'s hire secretaries are now being advocated by the Medical World, published in London. It calls for Government funds to provide secretarial assistance for any G.P. who's trying to handle 1,000 or more patients single-handed.

Part-time assistants, the journal says, would be enough for men with smaller practices, but those who have more than 3,000 patients should be eligible for full-time aides.

"The G.P. must have more time to spend on the work for which he was trained," the Medical World urges. "There must be some dilution of skilled medical with equally skilled non-medical personnel. It is in both the public and the professional interest that the general practitioner should be relieved of the enormous volume of clerical work."

Citing the case of an aide-less G.P., the journal chronicles the amount of paper-pushing he must do for himself: "Minutes are wasted per patient, hours per day, and weeks per year." On the other hand, a secretary can filter the doctor's correspondence, take out and replace patients' record cards, fill out certificates and repeat-prescription forms in preparation for his signature, type dictated letters to hospitals, and save him from the tedious telephoning to hospital surgeons that bulks so large on the British G.P.'s schedule.

"Let us make up our minds," it says "that what we need most is more time in the surgery [office]. More efficient organization of clerical work will give us that time. *This is the first aid we need.*"

## Doctors Score Political Firing of Hospital Head

"Politics should not be mixed with medicine and hospitalization," say a group of doctors in protesting the summary dismissal of a hospital superintendent. The issue has arisen in Prince Georges County, Md., where the county's all-Republican commissioners removed Harry W. Penn from his post as superintendent of Prince Georges General Hospital and and replaced him with a Republican.

The county medical society and the hospital medical staff promptly condemned the ousting. A statement of protest was placed before the county commissioners at a closed meeting, with representative physicians on hand to reinforce their criticism verbally.

Their objection was understood to be based on the political aspect of the dismissal. Staff doctors maintained that they knew of no "irregularity or incompetence in the

management of the hospital" by ex-superintendent Penn. Under the circumstances, they said, his removal would have to be regarded as purely political, and they intimated that politics might be less reliable than efficiency as a guide in selecting hospital administrators.

## Commercial Carriers Crowd Blue Shield

Dr. John W. Cline, new president of the AMA, has pointed out that insurance companies are giving stiff competition to California's Blue Shield plan, the California Physicians' Service.

"In the early days, CPS offered so much more than did the insurance companies that whenever it came into competition with them on straight medical coverage, it almost invariably won out," he recalls. The insurance companies had to offer a "package" that included disability, group life, and even other types of coverage in order to make any headway. But now they have cut down premiums and extended coverage so that CPS "competes with considerable difficulty for straight medical coverage."

Such competition is healthy, Dr. Cline believes. "It is important that the people . . . have an opportunity to choose between various types of coverage. The needs of some are better suited by one type than another . . . Competition and the different design of various plans ultimately will evolve the best coverage to suit the needs of the people."

## Zoning Crackdown Bars Medical Offices

Zoning restrictions on medical offices in residential districts have given some Maryland physicians an unexpected moving day. In the Montgomery County (Md.) suburbs of Washington, D.C., regulations ban any office not in a physician's bona fide residence.

A recent check-up of forty-four offices showed thirty-three safe on home base, eleven out. M.D.'s maintaining the separate offices were shooed off into commercial zones on ninety days' notice.

## Editor Hits Writer On Gouging Charge

"*Who* does the gouging?"

Thus did Editor Marjorie Shearon challenge Writer Albert Deutsch whose Woman's Home Companion article "Trouble in Our Hospitals" had accused physicians of unconscionable patient-gouging.

The editor of the Shearon Legislative Service told this first-hand story:

"Last week I entered my husband in a well-known New York hospital. I had to deposit $500 before the hospital would let the patient in, and I had to sign a guarantee to meet all future charges. The sur-


Successful therapeutic results with **VERATRITE** in essential hypertension are measured in terms of a fall in blood pressure, effective relief of symptoms and rehabilitation of the patient to a useful, productive life.

The most significant effects of **VERATRITE** are circulatory improvement and a new sense of well-being for the patient. Furthermore, Veratrite exhibits a wide range of therapeutic safety and a prolonged length of action without serious side-effects, due to its content of *whole-powdered* veratrum viride, Biologically Standardized.

**Supplied:** Bottles of 100, 500, 1000 at prescription pharmacies everywhere.

***ECONOMY IS AN IMPORTANT ADVANTAGE OF VERATRITE THERAPY***

**Each VERATRITE Tabule contains:**
**Veratrum Viride.....3 Crew Units***
**Sodium Nitrite.....1 grain**
**Phenobarbital.....¼ grain**
**Beginning Dose: 2 tabules t.i.d., after meals.**

***Biologically Standardized for toxicity by the Crew Duplein Hogan Assay.**

# Veratrite

**IRWIN, NEISLER & COMPANY** **DECATUR, ILLINOIS**

geon, in contrast, started his services and continued to give them without any advance or any guarantee. *Who* does the gouging?"

After a quick look at Deutsch's "scare article" in the Companion, Mrs. Shearon dug into the writer's background: "He is a strong booster for the Physicians Forum and an active protagonist of Government-controlled medicine."

She said she knew Deutsch from way back. In fact, she recalled a meeting more than fifteen years ago at which he had told her, "You petty bourgeosie should be liquidated. You're on the side of the capitalists."

## Broadcasts Dramatize Local Health Projects

A series of nation-wide radio broadcasts telling how health problems have been solved through community action and describing the role played by physicians in these projects was recently concluded over the NBC network. The series was sponsored jointly by NBC and the Health Information Foundation.

Five successive Saturday afternoon programs told the story of

¶ Rural Alexander County, N.C., where funds were raised to build a hospital and health center;

¶ A Negro community in Atlanta, Ga., where 15,000 persons were attracted to a multi-test screening clinic;

¶ Clinton County, Ohio, where a doorbell survey helped improve health and hygiene;

¶ Minneapolis, Minn., where citizen managers increased the efficiency of voluntary hospitals;

¶ Oakland, Calif., where physicians instituted a program assuring prompt 24-hour medical service.

## M.D. Jailed for Evasion; Patients Pay His Tax

The physician's profession entitles him to no automatic amnesty for tax fraud, a judge has ruled; he must pay the penalty even though patients plead that the community cannot spare him. This warning has come from a Federal court in Baltimore, in the case of The People vs. Wardrop.

The defendant was a 48-year-old M.D. of Silver Spring and Chevy Chase, Md. He was brought before the court on charges of tax evasion, of systematically concealing income amounting to $61,875 for the five-year period 1944-49. During that time he had evaded $24,150.26 in taxes, the U.S. Attorney said.

The physician pleaded guilty. Extravagances of his former wife had burdened him with yearly expenses of about $15,000 a year, his counsel brought out, leaving little for the tax collector.

Patients took the stand in his defense, testifying to his value to the community. In a panicky week-end rush, a citizens' committee made

## Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

Medical Economics, Inc.
Rutherford, N.J.

up largely of patients voluntarily collected $20,000 (nearly enough to cover the $24,150.26 in back taxes) and paid it to the U.S. Treasury on the doctor's behalf.

But when the defendant faced sentence, the judge ruled that doctors could not expect "preferential treatment merely because the community needed their services." Sentence: four months in prison and a $5,000 fine.

## DeVoto Implies Gag On Medical Press

"Opposition to the AMA party line is greater than the Journal [AMA] claims," announces author Bernard DeVoto, basing his opinion on fan mail that came to him after publication of his "Letter to a Family Doctor" in Harper's Magazine.

Response to this essay, in which DeVoto tossed a typewriter-ful of criticism at what he called "the advertising campaign conducted by the AMA," stuffed his mail box the fullest it had been in years, he says. The score, according to DeVoto:

¶ Of 91 letters from medical men, 80 per cent were pro-DeVoto, anti-AMA.

¶ Of messages on letterheads of hospitals, medical schools, or medical foundations, 100 per cent were anti-AMA.

These missives, he trusts, give a clearer picture of opposition to the AMA than has found its way into print in the Journal. He berates the Journal for allegedly discounting AMA critics as a negligible minor-

## When Lactation Fails

# Rx LACTOGEN®

When the supply of breast milk is inadequate or when lactation fails entirely, there is no better formula than Lactogen. Designed to resemble mother's milk, it consists of whole cow's milk modified with milk fat and milk sugar. It differs, however, in one important respect: the protein content of Lactogen in normal dilution is one-third greater than that of mother's milk—2.0% instead of 1.5%.

## A Complete Infant Formula In One Package

Lactogen contains all the ingredients of a well-balanced infant formula. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk.

## Easily Prepared... Merely Add Water

Lactogen is simple to use. The prescribed amount is stirred into warm, previously boiled water. Either a single feeding can be prepared, or the entire day's quantity can be made up and stored in the refrigerator until used.

**THE NESTLÉ COMPANY, INC.**

COLORADO SPRINGS, COLORADO

**NOTABLY HIGH IN PROTEIN CONTENT**

Lactogen contains a generous amount of protein... more than enough to satisfy every protein need of the rapidly growing infant.

ity and for denying them the space devoted to majority interests.

After quoting the JAMA editor as saying the Journal prints "opposing opinion," he quotes correspondents who say it usually doesn't. Fifteen correspondents told him, in fact, that such sentiments would not likely be published in *any* county, state, or national medical journal. (His "Letter" was reprinted in MEDICAL ECONOMICS; national circulation, 134,000.)

Sample brickbat from DeVoto mail:

"Official medical opinion is revealed through the medical press, and the medical press is a kept press, providing as little freedom of expression as do the news organs of a totalitarian nation. Those who raise the voice of protest run the risk of liquidation."

DeVoto cites the "terrorism" by which the AMA keeps a medical man cowed into silence: "He might be dropped from his local society and thereby, or by equivalent means, be made ineligible for hospital staffs, and so, effectively, barred from the practice of medicine."

He then quotes one of his correspondents to prove the point: "God damn it, as a specialist I cannot quit the AMA and its lobby without losing my specialist memberships; I am helpless."

His report closes without reference to medical men who aired their views about his "Letter" by writing to MEDICAL ECONOMICS. They were anti-DeVoto, pro-AMA in the ratio of 8 to 1.

## Medical Schools Short Of 'Real Teachers'?

The issue of financial aid for medical schools has been complicated by an accusation that their faculties are staffed with many who aren't "real teachers." These fighting words come from John M. Russell, executive director of the John and Mary R. Markle Foundation.

Mr. Russell distinguishes eight types of medical professors:

1. "Those who can't do anything else";
2. Dilettantes, who have private incomes or rich wives;
3. Cardiacs, who escape the strain of practice by teaching;
4. Loafers, who choose teaching under the illusion that it's easy;
5. Go-getters, who "use medical schools as an advertising medium";
6. Softies, who can't cope with patients or competition;
7. Missionaries, who are deserting the heathen in favor of serving medical science and future doctors;
8. "Real teachers."

But Mr. Russell is not denying that schools need aid. While collecting ammunition for his pot shots at faculty members, he is distributing nearly $2 million of Markle

# DOCTOR . . . when a baby skin preparation is indicated, consider these facts about Johnson's Baby Lotion:

## JOHNSON'S BABY LOTION

### ACTIVE INGREDIENTS

Medicinal grade mineral oil in a highly emulsified state

Lanolin

Hexachlorophene (1%)—antiseptic effective against both gram positive and gram negative organisms.

### THERAPEUTIC INDICATIONS

Prevention or treatment of

IMPETIGO CONTAGIOSA
MILIARIA RUBRA
DIAPER RASH (Ammoniacal Dermatitis)
EXCORIATED BUTTOCKS
CRADLE CAP

### CLINICAL EVIDENCE

Bacteriostatic and bactericidal properties of the lotion confirmed by exhaustive hospital tests of over 10,000 baby days. Lotion reduced the incidence of skin irritations of *all* types to an average of less than 2%.

### ADVANTAGES

Exerts prolonged antibacterial action; nonirritating, nontoxic. Forms a discontinuous film which provides protection without blocking the metabolic and respiratory functions of the skin. Possesses powerful buffering action neutralizing both excessive acidity and alkalinity in the stool.


JOHNSON'S BABY LOTION

Johnson & Johnson

funds to medical schools to supplement the salaries of teachers. "Real teachers," that is.

## Advocates National Licensure System

Charging that in most states the medical licensure board "is a child of the state medical society" and an archaic barrier to the free movement of physicians, Dr. Sidney M. Greenberg, editor of the Physician's Forum Bulletin, calls for a "long overdue" national system of licensure.

Protection of certain professional interests rather than promotion of public welfare is beginning to motivate these state boards, Dr. Greenberg holds. Two such selfish aims, he says, are: "Control over the number of doctors allowed to practice in a state and over the character or point of view of doctors licensed to practice."

As an example of the first sin, he states that "the licensure boards in many states, whose people are desperately short of doctors, have for years consciously excluded more than a 'satisfactory number' of physicians from local practice.

"Another twist on licensure board authority," Dr. Greenberg adds, "is the 1948 examination in internal medicine given by the West Virginia board. Two questions read as follows: 'Summarize in one page your thought on the Social Aspects of Medicine' and 'Summarize in one page your thought on Prepaid Health Insurance.'"

Dr. Greenberg's conclusion: "One needn't ponder long on the grade a candidate would receive who answered either of these questions with an opinion favorable to nation-wide health insurance."

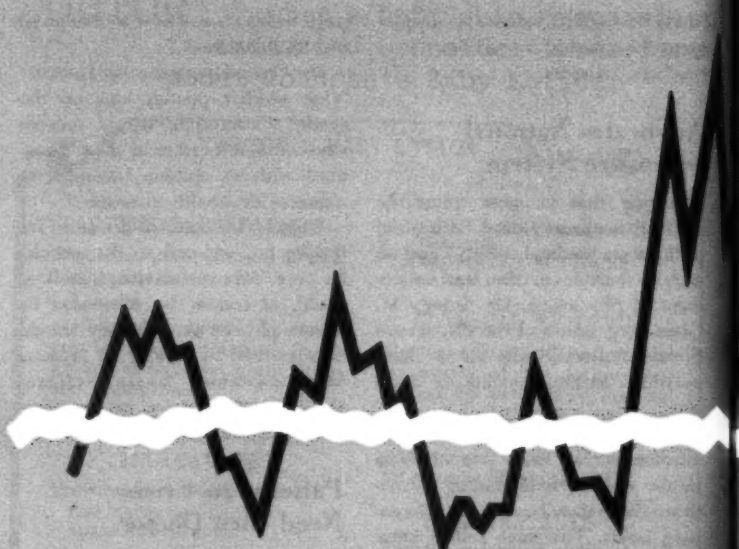
Urging that medical licensure authority be returned to the people, he says: "Examination questions could, of course, be composed by expert physicians, but they should be reviewed by intelligent laymen. More important, basic policies should be formulated by representatives of the people to be served."

## Patients in Crisis Need Own Doctor

Emergency call services may locate a doctor with life-saving speed, but they fail to provide the "interested personal attention which is the very essence of the practice of medicine." So says the magazine GP.

Many county societies, it grants, have arranged for stand-by physicians to answer emergency calls at any hour; but they send *a* doctor, not *the* doctor.

Patients, says GP, should be able to rely on a particular physician in emergencies. "They should know him and he should know them. They should know that they can always reach him or that if he is out of town they will reach another friendly physician who will take his calls." Then their first and only



*In each tablet, equa
or 5 cc. (tsp.) of Eli

Hyoscyamine Sulfate ..... 0.1037 m
Atropine Sulfate ..... 0.0194 m
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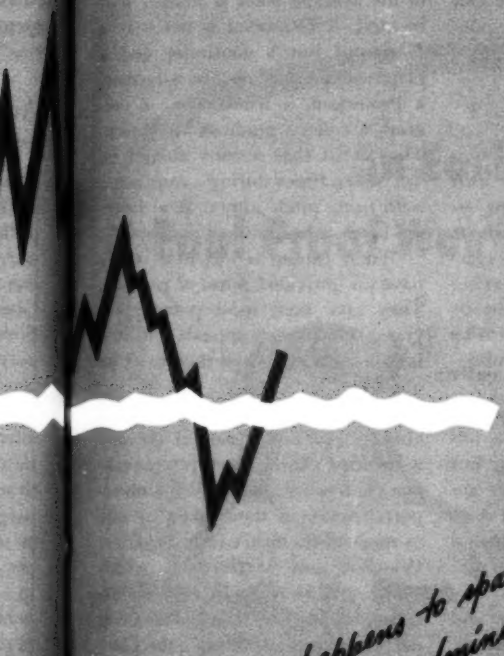

*this is what happens to spasm shortly following the administration of that excellent combination of natural belladonna alkaloids with minimal phenobarbital*...*

Robins

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*is a product of* **A. H. ROBINS CO., INC.**
**RICHMOND 20, VA.**
***Ethical Pharmaceuticals of Merit since 1878***

thought, says GP, will be to call "that man on whom they . . . depend in time of distress."

## The Nation Profiles Whitaker and Baxter

"Government by Whitaker and Baxter" is the title of a recent series of articles in The Nation, about the husband-and-wife public relations team that has been serving the AMA. The magazine sub-headlines the three-part profile as "The Triumph of Chrome-plated Publicity."

Carey McWilliams, writer of the series, disapproves of what his fellow Californians are doing, but seems to approve the way they are doing it. His articles are about their public relations business in general rather than about their AMA campaign in particular.

He analyzes the Whitaker and Baxter strategy and tactics with unconcealed admiration, even though he declines to give the team credit for believing in what it is doing:

"Their general strategy is to prime the grass-roots vote . . . It says in their book that close elections are decided by the independent vote, and that this vote seldom makes up its mind until the Friday before the first Tuesday in November . . .

"In their experience, the American voter resents classification . . . At the same time they are well aware that the political personality of the average voter is sharply segmented. A Democrat is not only a Democrat but a consumer and a taxpayer; he may also be a farmer, a Protestant, a truckdriver, a veteran, a college graduate, a Mason. They insist that a voter should be 'hit' seven times during a campaign, with each 'pitch' aimed at a different facet of his political personality.

"Their timing is superb; they have an unrivaled sense of pace . . . They save their most potent programs and stirring appeals until the last—'to sell 'em when they can't be unsold' . . . "

What Whitaker and Baxter thinks about a particular issue of the day is decided during a two-hour breakfast conference, Mr. McWilliams reports. Action is then taken by one or more of the firm's four divisions: Whitaker and Baxter itself, which handles political public relations exclusively and is thus "something new in American politics"; the Clem Whitaker Advertising Agency; the California Feature (news) Service; and Campaigns, Inc.

Among the fifty rules Whitaker and Baxter has formulated for running campaigns is No. 8: "You Can't Beat Something With Nothing." Thus doctors are encouraged not to harp only on *compulsory* health insurance but to talk about *voluntary* health insurance.

The Whitakers, both former members of the Fourth Estate, see to it that California's 700 newspapers are well cared for. While the

# An Easier, Fool Proof Way for Mothers

to administer aspirin to children in *exact* dosage in any vehicle you prescribe.


2½ GRS. GROOVED TABLETS EASILY HALVED 1¼ GRS.

- UNCOLORED—UNFLAVORED
- Can't be mistaken for Candy

BY THE MAKERS OF *Genuine* BAYER ASPIRIN

*...The Analgesic for home use*


# A MORE ADEQUATE APPROACH TO MENOPAUSAL THERAPY

**TRANSIBARB** Capsules provide threefold, symptomatic relief in the management of the menopausal patient . . . adequate sedation . . . cerebral stimulation . . . control of vasomotor instability.

TRANSIBARB takes full advantage of the increasing use of a central nervous system stimulant combined with effective proportions of sedative medication. In addition, vitamin E is employed in the formula for its demonstrated efficacy in menopausal therapy.

In geriatrics, too, TRANSIBARB tends to minimize nervous apprehension in debilitated and mentally depressed patients.

Each TRANSIBARB Capsule contains phenobarbital, (Warning: May be habit forming), ¼ gr., d-desoxyephedrine HCl, 2.5 mg., and vitamin E (dl-alpha tocopheryl acetate), 5 mg.

DOSAGE: One capsule, an hour after breakfast; one capsule, an hour after lunch. In exceptional cases, a third capsule may be given, if required, an hour after the evening meal.

# TRANSIBARB

TRADEMARK

**Sedative—Sympathomimetic**

**SUPPLIED: Bottles of 500 and 1000 capsules, at all drug stores.**

*Literature and samples to physicians on request.*

BREON

George A. Breon & Company

*Pharmaceutical Chemists*

NEW YORK 18, N. Y.

Clem Whitaker ad agency collects the usual 15 per cent commission on such business as radio and billboard advertising, it does not take its cut from newspapers (except in recent years in the case of a few metropolitan dailies). "This policy," McWilliams writes, "has made the words 'Whitaker and Baxter' music to the ears of small-town editors."

The small-town editor is, of course, a vital link with the grass roots. What's more, McWilliams points out, the sacrifice of advertising commissions is not so costly as might be supposed. This agrees with Whitaker and Baxter's thinking on the subject:

"It is cheaper in the long run to lobby the people than to lobby their servants [legislators] . . . The favors of a lobbyist need only be acknowledged in the session in which they are accepted. But a campaign won as a public issue will stay won—for some years at least."

Author McWilliams, an active California liberal, has watched Whitaker and Baxter operate on the West Coast for a long time. "These talented hucksters," he writes, "have had more direct influence on California's legislation in the last fifteen years . . . than any combination of politicians or of special-interest groups." Their 15-year state record: fifty-five out of sixty-five campaigns won.

Clem Whitaker's father, Mr. McWilliams reports, was a Baptist minister and a Republican; his Uncle Robert was a minister and one of California's most prominent Socialists.

Whitaker's first successful political job was steering a bill for the state board of barber examiners through the California legislature. His barber had put the bee in his ear, and from then on he was in politics. Today, according to McWilliams, Clem Whitaker "knows more about politics than any other living Californian."

Leone Baxter was once manager of the Chamber of Commerce at Redding, the political hub of northern California. "A beautiful young lady with red hair, green eyes, and deceptive mildness of voice," she joined forces with Whitaker in a 1933 campaign.

Who's boss?

Says McWilliams: "There is no division of functions between the partners; on the contrary, they insist on being interchangeable in all phases of their work, on reflecting a single point of view." This, he concludes, "makes for a nearly perfect fusion of the male and female . . . in American politics."

## Films Pit History Against Socialism

Doctors have been introduced to "Land of the Free," a series of slide-films with sound, designed to carry an anti-socialist message to small groups in any locality.

The Detroit advertising agency


## Why Alhydrox Adsorbed Dip-Pert-Tet* fits your pediatric picture

**POTENT**—Alhydrox increases the antigenicity of Dip-Pert-Tet. It helps build maximum, durable immunity simultaneously against Diphtheria, Pertussis, Tetanus. Each basic immunization course contains the high pertussis count of 45,000 million Phase 1 H. pertussis organisms. In actual use as well as reported clinical studies[1] it has been shown that Dip-Pert-Tet Alhydrox produces uniformly superior levels of serum antitoxins.

**PURIFIED**—Dip-Pert-Tet Alhydrox reduces reaction frequency. Try it—compare it in your own practice. You will see that undesirable reactions are reduced to a minimum with purified Dip-Pert-Tet Alhydrox.

**Put Dip-Pert-Tet Alhydrox in your pediatric picture.** You can depend on it for simultaneous immunization against Diphtheria, Pertussis, Tetanus. *Cutter Laboratories, Berkeley, California*—Producers of famous purified Dip-Pert-Tet Plain, a product of choice for immunizing older children and adults.

* *Dip-Pert-Tet Alhydrox*
*—Purified Diphtheria and Tetanus Toxoids and Pertussis Vaccine combined, Aluminum Hydroxide adsorbed.*

## Insist on CUTTER DIP-PERT-TET ALHYDROX®

A FIRST NAME IN COMBINED TOXOIDS

[1] *References on request*

Cutter Laboratories, Berkeley, California.

of Ross Roy, Inc., originally produced the slide-films for business men to sponsor in their home towns. Then the agency suggested to the Association of American Physicians and Surgeons that medical men also could profit from showings, in the campaign against socialized medicine. Result: The AAPS arranged for an agency representative to exhibit and discuss the films before the Chicago interim meeting of its house of delegates.

In making the slide-films, the agency selected incidents from stories of ancient Greece and Rome and from pre-Revolutionary American history to illustrate the dangers of relying on the government for security.

## Dentist Takes to Woods; Patients Follow

Professional men who hanker for retirement pastimes but don't want to retire will envy Wisconsin dentist Irving L. Cook. He has moved his office into the woods near a trout stream, where he combines a profitable career with his favorite sport.

For a quarter-century the dentist practiced in his home town of Gillett, Wis., dreaming all the while of a certain horseshoe bend in the Oconto River twenty-five miles away. He could hardly wait till retirement age to build a house and live there.

One day it occurred to him that if he had a stream-side office and specialized in false teeth, patients, during their temporary toothlessness, would value the seclusion as well as a little trout fishing on the side. He was right. Now they come to him from several states to combine the inevitable with a vacation —in privacy.

He has put up a six-room house in the crook of the stream, with a six-room dental suite attached. There's also a separate cottage for patients, plus garage space.

Big windows let the patient in the dentist's chair watch the trout leap in the stream or see an occasional deer come to drink.

Mrs. Cook, who serves as her husband's assistant, arranges appointments so that the dentist has ample time for relaxation. When he gets tired of work, he can pull on his waders and, a minute later, step into the stream with his fly rod.

"Best gamble I ever took," he remarks. "Why should I think of retiring now?"

## Letters Debate Whether AMA Deserves the $25

"A strong protest" by a doctor against AMA policies has broken into print in the New England Journal of Medicine. The doctor is Charles A. Janeway, Harvard professor of pediatrics, and his challenge to the AMA is voiced in a letter he wrote to the Massachusetts Medical Society when paying his

# ABOLISH PAIN RESTORE FUNCTION IN THE *Arthritic*

The thousands of once disabled arthritics, who have taken DARTHRONOL as part of a systemic rehabilitation program and returned to gainful and active life, are evidence of the efficacy of DARTHRONOL in:

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**EACH CAPSULE CONTAINS**

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| Vitamin D (Irradiated Ergosterol) | 50,000 U.S.P. Units |
| Vitamin A (Refined Fish Liver Oil) | 5,000 U.S.P. Units |
| Vitamin C (Ascorbic Acid) | 75 mg. |
| Vitamin $B_1$ (Thiamine Hydrochloride) | 3 mg. |
| Vitamin $B_2$ (Riboflavin) | 2 mg. |
| Vitamin $B_6$ (Pyridoxine Hydrochloride) | 0.3 mg. |
| Niacinamide | 15 mg. |
| Calcium Pantothenate | 1 mg. |
| Mixed Tocopherols (Type IV) | 4 mg. |

*Specify* **Darthronol**

**J. B. ROERIG AND COMPANY** 536 LAKE SHORE DR., CHICAGO 11, ILLINOIS

AMA dues. The journal published his letter, along with an answer from Dr. Earle M. Chapman, one of the society's delegates to the AMA.

Dr. Janeway leads off: "I am enclosing check for $25 for my AMA assessment. I do so because payment of this assessment has been ruled as necessary for members by the representatives of the profession; and, as a believer in democracy, I must accept the rule of the majority, even though I don't like it."

Dr. Chapman's response to this: "I wish there were more like you who would pay their dues and continue to stay in the medical societies and perhaps play an effective role in formulating the policies of the AMA . . . The tired old men who ruled for years are being replaced by young, vigorous men who think clearly," he assures his colleague. "We need you there too."

Dr. Janeway states his forthright opposition: "I should like a strong protest to accompany my check . . . It is most heartening that such a large proportion of the members of the Massachusetts Medical Society have failed to pay the $25, because it indicates widespread dissatisfaction on the part of the rank and file of the profession with the policies and tactics of the national organization. My own dissatisfaction arises on two main counts."

The first of these, he says, is "fundamental disagreement with a basic tenet of AMA policy that only doctors are competent or even entitled to plan the organization of medical care . . . To exclude the consumer of medical care from a voice in how it may best be organized seems very strange."

In rebuttal, Dr. Chapman states that this is no longer AMA policy. He cites AMA committees for improving health services in industry, for laymen-sponsored medical-care plans, and for rural health as examples of AMA cooperation with laymen on planning. He reminds his colleague that two-thirds of the governing body of the Massachusetts Blue Shield plan are nonmedical folk.

The second source of Dr. Janeway's disaffection is "fundamental disagreement with the AMA tactics . . . of working *against* 'socialized medicine' instead of *for an aggressive program* of its own."

Dr. Chapman replies: "I quite agree with you, and I have become involved in AMA affairs in the past two years because of this same feeling. I think the tide is turning."

Janeway: "Organized medicine should provide the leadership in improving medical care as a social institution."

Chapman: "Doctors stand ready and are trying to help . . . but the battle has been one of costs—and many other components. Will the cost be greater under the government-insurance and handout scheme or will it be less if local communi-

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ties encourage insurance through all means and the present system continues and improves? That is squarely the issue. I personally favor the latter. So does the AMA."

Janeway: "[Organized medicine] ought to be leading the fight for wise bills in Congress and working to draft legislation, instead of running the most expensive lobby in Washington to block medical-care legislation."

Chapman: "Now, just a word about 'the most expensive lobby in Washington.' The AMA does maintain a registered lobby in Washington . . . Last year this office cost the AMA $87,523.21. Against this, the Council on Medical Education and Hospitals spent $193,800.49. Now, through this listening post, we were able in 1949-50 to be *for something*: . . . the National Science Foundation Bill . . . . the 'doctor-draft' law . . . . Hill-Burton hospital construction . . . . expansion of local public health units . . . . a Federal Department of Health . . . . the Hoover-directed report on medical education."

Janeway: "The profession has a moral obligation to provide such leadership; strategically it will do more to stop a comprehensive system of government medicine than the present tactics . . . In general, we find ourselves repeatedly supporting programs to which we were bitterly opposed several years before, but only when it's too late and we've already acquired the reputation of being obstructionists."

Chapman: "Back in the 1930's the AMA did oppose voluntary insurance, but *today their policy* is to push all forms of insurance or prepayment-of-medical-care plans."

Dr. Janeway concludes: "I do hate to see the organization that represents our professional nationally . . . get the reputation, which it has certainly acquired, of being against all social change. It should be the leader in promoting wise programs for spreading the benefits of modern medicine as widely as possible—programs . . . carried out in co-operation with the general public and with the representatives of governmental and private agencies."

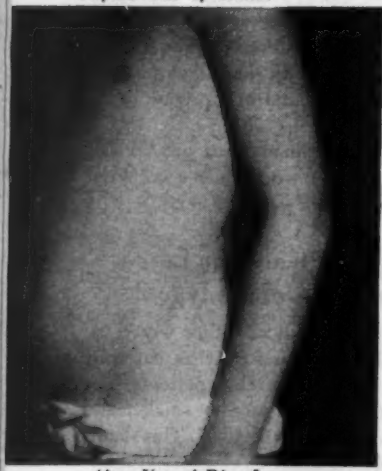
Dr. Chapman signs off: "Yours for a better world to live in. What do you want us to do next?"

## Editor Pleads for Less Medical Gobbledygook

"If every medical author would examine his manuscript as carefully as he examines his patients, our journals would be a lot smaller and a lot more readable!" This latest outcry against "medical gobbledygook" comes from long-suffering Dr. Clifford L. Graves, associate editor of the Bulletin of the San Diego County Medical Society.

Target of Dr. Graves' wrath is medical language that's "pompous, verbose, vague, stilted, illiterate." Instead of saying that two people

*Before Use of Riasol*



*After Use of Riasol*

# Not Modesty... ...PSORIASIS

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RIASOL FOR PSORIASIS

fell in love and got married, too many doctors, he claims, put it this way: "Their libidinous impulses being reciprocal, the two subjects henceforth projected their erotic drives within the same frame of reference." Impressive all right, observes Dr. Graves, but a poor excuse for English.

Behind gobbledygook lies muddled thinking. In a book by a well-known medical author, Dr. Graves came across this mouthful: "The studies of Leithauser upon early ambulation which is being recognized as an important factor in reducing our post-operative morbidity is utilized to the greatest advantage in our simplified free-flow-of-mercury tube."

What's being utilized here—Leithauser, his studies, or early ambulation? The reader can only guess. Says Dr. Graves: "A sentence should point straight, like a furrow in the ground." It should also obey the elementary rules of grammar and punctuation.

But the fatal error is wordiness. A professor of surgery wrote in a recent article: "Recognizing that studies of specific prophylactic and therapeutic measures were in progress elsewhere, reliance was not placed on any of the currently recommended methods of prophylaxis and treatment, but rather an effort was made to stress the use of several supposedly helpful general prophylactic measures and to individualize the use of anticoagulants and proximal vein ligation, once the diagnosis of thrombosis was made."

Suppose he'd concentrated on what he really wanted to say? The Graves version: "All we wanted to do was to find out what our current treatment of thrombosis really accomplishes." The dangling participle is gone, and the sentence is forty-seven words shorter. "Gobbledygook is poor economy," concluded Dr. Graves.

## Incentive Added To Hold E Bonds

Faced with the prospect of paying out $5 billion this year and next, the U.S. Treasury is wooing investors with a new interest arrangement for maturing Series E savings bonds.

Bonds that have matured after May 1 may be held for interest of 2½ per cent each year up to seven and a half years. Thereafter the yield will rise to an average of 3 1/3 per cent of simple interest for each year of ten years (equivalent to interest of 2.9 per cent compounded semi-annually for the ten-year period).

Thus a 10-year-old $75 E bond now worth $100 will bring the holder, say, $105 in another two years. If kept for 10 years it will yield $133.33.

Previously, an E bond could not draw interest after maturity. And if the proceeds were reinvested in a new E bond, the rate of interest

was less 1 per cent for the first two years. Formerly, an investor had to hold his new E bond the full ten years in order to make commensurate interest.

Under the new law, E bonds are extended automatically, and interest will accumulate as long as the bond is held. Whenever the bond is cashed, interest for the total period will be computed on the face value.

Reinvestment of matured E bonds in other U.S. bonds bought in the open market can be risky, since the investor has no assurance that he can always redeem the bonds at face value. Market fluctuations might pull the price down. The E bond, however, will pay on demand at any time the full amount invested plus interest.

A satisfactory alternative for interest-minded investors is the Series G savings bond, a pay-as-you-go bond that matures in twelve years. Interest at 2½ per cent is mailed semi-annually to registered owners. A $1,000 G bond will pay a $300 profit over the twelve year period.

G bonds obtained through exchange of mature E Bonds can be cashed in at face value after six months. Ordinarily, a G bond cashed in before the end of twelve years will bring less than the face value, although the interest already received usually makes up the difference.

The Treasury or any Federal Reserve Bank or branch will make E-G exchanges in denominations of

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| Thiamine HCl | 0.16 mg. | 0.7 mg. |
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| Niacin | 0.17 mg. | 6.4 mg. |
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| Vitamin D | 4 I.U. | 150 I.U. |
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*Egg-nog nutritive values from Bowes, A. de P., and Church, C. F.: Food Values of Portions Commonly Used. Philadelphia, 1944; fifth edition.

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$500, $1,000, $5,000 and $10,000. Requests for exchange must be made within two months after the E bonds' maturity, although you may accumulate maturing E's for twelve months and request the exchange after maturity of the final bond.

## 60 Per Cent of State Has Prepay Insurance

More than 60 per cent of the 8,700,000 people in Illinois now have hospital care coverage of some sort, the Illinois State Medical Society reports. About 30 per cent also have surgical care coverage.

To critics who claim that voluntary health insurance is too limited in its coverage, the society has this comeback:

"The public does not feel any compelling need to insist on 100 per cent coverage for its health care cost risks, any more than it does in fire, theft, or auto insurance. It is content with that amount of insurance which it can afford and which is also sufficient to take most, not all, of the load of health care costs."

## Out-Front CD Group Gets Own Manual

Medical mobilization for civilian defense in Alameda County, Calif., has progressed so far that Alamedans have even written their own first-aid manual.

The energetic East Bay Medical Disaster Committee has consolidated doctors, technicians, and

# *Questions and Answers*

## *about the new*

# Picker-Polaroid *one minute* radiograph

On March 7, 1951, before the Surgeon General and the staff of the Bethesda Naval Hospital, the Navy demonstrated the Land Process for making one-minute radiographs. The significance of this demonstration and a subsequent televised demonstration on the deck of the U.S.S. Salem was immediately sensed not only by the medical profession but by the press. *To answer the hundreds of inquiries which have been pouring in, we are making this report to you:*

### what is the process?

The one-minute, self-development principle of the Polaroid* Land Process, applied to radiography.

### what does it do?

It produces a dry, finished radiograph, ready for use, one minute after the exposure is made, *without darkroom processing.*

### how does it work?

1 You place the Polaroid x-ray packet in a special daylight-loading 10" x 12" Picker-Polaroid cassette, which fits any standard cassette tray.

2 Make a normal exposure in the usual way, with any x-ray machine.

3 Place the cassette in an automatic motor-driven processing box. Press a button...

4 A minute later, remove the finished print, dry and ready for use. There are no liquids present, no chemicals to handle.

### what does the radiograph look like?

The image is a positive x-ray image on glossy white paper. It has excellent gradation and good density. You study it without using an illuminator.

### is a darkroom needed?

No; you can load and process the radiograph in full daylight.

### how will it be used?

While actual clinical experience has been limited, those who have participated during the past few years in the experimental adaptation of the process to x-ray (among them the radiological staff of the Massachusetts General Hospital in Boston) have predicted great usefulness in a variety of procedures: for fracture work, foreign body location, hip pinning and other work where speed is important. It should be useful in the many situations where darkroom facilities are not available or conveniently usable.

### what will it cost?

Somewhat more than the direct cost of conventional x-ray film of similar size. When savings in processing, waiting and handling costs are considered, the actual cost difference may vanish.

### when will it be available?

*The entire output will go first to the Armed Services.* It is hoped that by early 1952 production will have reached the point where civilian deliveries can start.

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nurses of the Berkeley, Oakland, Alameda, San Leandro, and Hayward areas into a single civil defense unit. The organization is so extensive that it has twenty coordinators.

The committee has lined up disaster teams of medical men for sixteen hospitals. There is a team member each for admission, evacuation, shock, burns, surgery, orthopedics, X-ray, laboratory, and anesthesia—to say nothing of that perennial emergency, obstetrics. Specialty teams stand by at designated hospitals to handle thoracic surgery, neurosurgery, and plastic surgery.

Supplementing the hospitals, the disaster committee has set up forty-three first-aid casualty centers. Twenty-seven are in school buildings. Sixteen are mobile units with bases in schools. That means forty-three separate staffs, each with a full complement of doctors, nurses, and first-aiders.

They're ready, too. Identification cards and passes have been issued. The staffs are now meeting as groups, to get acquainted with their team-mates, equipment, and surroundings. Each casualty center has an estimated two hours' supplies on hand.

To promote standard procedure throughout its varied and scattered centers, the East Bay Disaster Committee early started a search for a manual. They wanted one as well geared to the pathology of atomic blast as the rest of their set-up is. Finally they asked members of the

Alameda-Contra Costa Medical Association to write one.

Result: their up-to-date "Manual for the Emergency Field Treatment of Casualties." It's one of the first to be put together by private physicians rather than by a government agency. Its ten loose-leaf pages outline procedure for sorting casualties, identification, sedation, transportation, and priority of attention, as well as first aid. It includes suggestions for the family physician's follow-up care of burns after emergency treatment.

Now well girded for atomic catastrophe, the committee says its medical machinery won't snub a plain natural disaster. It'll go into action at need without being fazed by earthquake, fire, hell, or high water.

## Society to Put Ambitious Medical Program on TV

Authentic medical information is promised the public via a TV network program to be fostered weekly by the Medical Society of the County of New York. Plans call for a three-year series of televised discussions. In each one a layman will question a different panel of top medical men.

A society member, Dr. Lester L. Coleman, otolaryngologist, will be the producer, using professional TV personnel for script and production. He expects to start pouring medicine through the coaxial cables next fall.

The program will probably have

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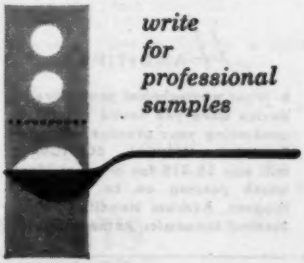

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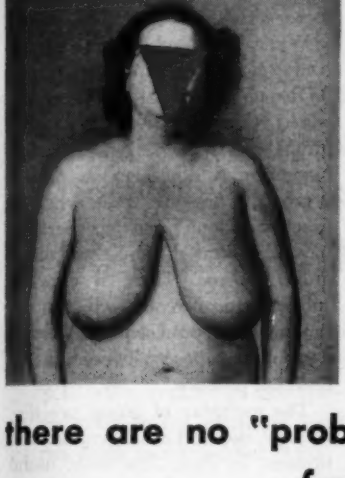
a commercial sponsor. This, it is felt, will insure enough money to hire actors and production people of the caliber to compete successfully with Milton Berle and Faye Emerson. Any income above expenses will be split between the producer and a non-profit foundation set up by the New York society.

The society will retain absolute control over the choice of sponsors and the wording of commercials, as well as over the selection of guest doctors and all other details of the program's contents. A special nine-man television committee will supervise the programming.

What about the ethics of having medical men ride TV channels in the hoofprints of Hopalong Cassidy? The society expects no kicks. The AMA gives its local units a good deal of leeway in interpreting ethical principles; and the New York society is approving the appearance of doctors on its program as "in the best interests of the profession and not for self-laudation."

The AMA and state and county societies are being invited to join in sponsorship. Each sponsoring group will nominate a director for the foundation handling the money and will also nominate men to take part in the panel discussions. The New York society, because of its Manhattan location next door to TV headquarters, expects to bear the brunt of supervising the program for accuracy and ethics.

Letters from the TV public asking medical advice will not be



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answered by panel experts. Instead, they'll be referred to the county medical associations in the communities from which they were mailed. Thus, the New York society hopes the program will build confidence in local physicians.

## Pioneers Needed In Group Practice

Development of group practice, says Dr. Louis B. Laplace, president of the Philadelphia County Medical Society, is one of the most important research problems in administrative medicine today.

"Group practice," he thinks, "offers satisfaction in unrestrained discussion of clinical problems with associates. It also offers greater financial security; and, through sharing of responsibility, it permits a more systematic and normal life."

While Dr. Laplace actively encourages more group participation, he does not feel that all doctors are suited to it. "Disadvantages of the group," he states, "are important to recognize. A physician, as part of a group, is less free than when he practices alone, and his personal income is limited to his share of the group income. There is also the subtle factor of rivalry which sometimes occurs between members of a group and those who continue individual practice."

The mainstay of group practice, he says, should be the general practitioner. In fact, "the most useful organization is one composed pre-

*New—*

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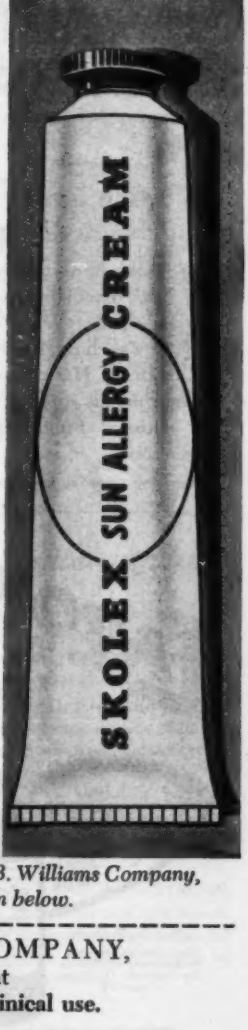


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dominantly of general practitioners who have as their associates a group of consultant specialists. A fundamental of good medical practice is that the care of the individual patient should be supervised by one physician of broad interest and experience."

## Education Fund Launched by Hoover

"The most important meeting in New York since the end of World War II."

That was how President James B. Conant of Harvard summed up the auspicious public send-off of the National Fund for Medical Education*.

*See May MEDICAL ECONOMICS, page 183.

The fund was, indeed, away to a flying start, what with the blessing of threescore notables and more than a million dollars in its coffers.

The public announcement about it also brought news of a formal tie-up with the AMA's American Medical Education Foundation. Contributions to the AMA foundation henceforth will be funneled through the NFME, which is set up to make the grants immediately available to the nation's medical schools.

Dr. Elmer L. Henderson told the national fund meeting that the AMA would continue to seek contributions from its members each year.

In acknowledging the million dollars already contributed, NFME President F. Sloan Colt (also presi-

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dent of Manhattan's Bankers Trust Co.) set the goal for the first year at $5 million.

"This sum will not solve the financial problems of America's medical schools completely," Mr. Colt said, "but it represents an important voluntary effort and the uniting of a broadly representative group who, though they may have differing social viewpoints, have dedicated themselves to the common good."

In the keynote address, former President Herbert Hoover, the fund's honorary chairman, called the fund-launching a "significant development in strengthening the nation's medical manpower."

Mr. Hoover told the gathering of industrialists, educators, scientists, and leaders in other fields that "there can be no question that this country is short of medical skills."

"I have a theory," the former President stated, "that if it had not been for the so-called wonder drugs which have shortened the time required by doctors on special cases, you and I would have to queue up and wait for somebody to die in order to get a doctor."

Many universities, Mr. Hoover said, had considered "a reduction of the field covered by their medical colleges." In one case, he added, there was a suspended decision to abolish the medical school altogether because it was too great a financial drag.

"We need to support these independent institutions through a very special economic crisis," Mr. Hoover

declared. "We cannot leave all these things to government. If we do, the impulses of progress that constantly lift the standards of education in the United States will be disastrously injured.

"The efficiency of practically all our industry and commerce today is dependent upon the health of the employes. Yet industry and commerce are obtaining their medical protection at the cost of somebody else. Therefore, I have no hesitation in suggesting that one of the major burdens in the support of medical education should be placed on the shoulders of the business world."

Others who spoke at the send-off meeting were President Harold E. Stassen of the University of Pennsylvania; Dean Joseph C. Hinsey of Cornell University Medical College; and representatives of the A.F. of L. and the C.I.O.

A cable to Mr. Hoover from General of the Army Eisenhower, who had been active in the fund during its two-year organizational period, read: "I cannot fail to testify to my belief in the great value to America of the work you and your associates are doing."

Support for NFME came also from the Commission on Financing Higher Education, a research group sponsored by the Association of American Universities and financed by the Rockefeller Foundation and the Carnegie Corporation.

The commission, whose analysis of medical education was released coincidentally with the public announcement of NFME, recommend-

ed the national fund as appropriate machinery for stimulating much-needed corporate support of medical education.

During the NFME meeting, however, Dr. Conant took sharp issue with that part of the CFHE report which declared that "medical deans and medical schools have not yet demonstrated that their operations are adequately economical and efficient." The higher education group had warned that outside investigation might be necessary to effect economies "to eliminate costly practices."

Replied Harvard's president: "If by economies they mean simply cutting budgets, of course, it can be done. If, however, by economies they mean saving money and doing equally as good a job, I submit they are mistaken. It would be my judgment from personal knowledge at Harvard and from looking over the fence at other medical schools that budgets have already been cut to the bone."

Aside from "economies," the commission suggested that medical schools consider these "new sources of income": financing by patient charges or by local welfare appropriations the hospital care and other community services now provided by medical schools; full support of medical research by foundations, corporations, and other agencies that do not now bear the indirect costs of such research; increased appropriations for medical education through new state taxes.

## *Memo from the Publisher*

● "Time brings all things," a departmental caption in that weekly news magazine used to aver. The same might be said of our own monthly grab-bag of special-interest items for the M.D. We're talking about that back-of-the-book department we call The Newsvane.

Some twenty or thirty brief stories each month comprise this built-in kaleidoscope. A good many are *progress reports*. These bring you up-to-date on major developments discussed earlier in full-length MEDICAL ECONOMICS articles. Recent items of this type have told you what's happening in the hospital accreditation row, the controversy over Rx refills, the British medical muddle.

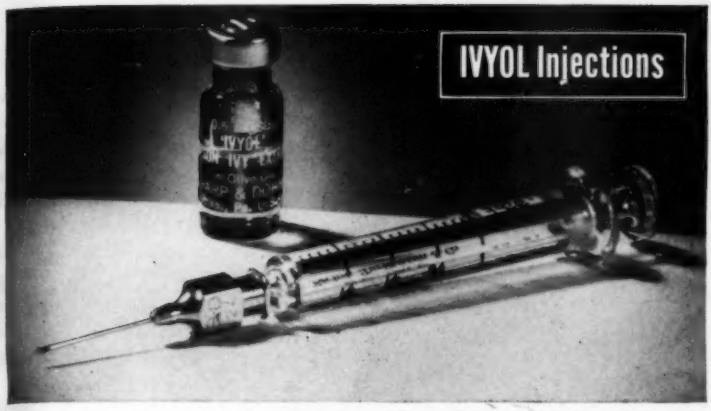
Another Newsvane staple might be described as *quick quotes*—pungent comment distilled from speeches, reports, and staff interviews. Typical examples have been Dr. Joseph Hinsey's views on medical school standards ("One thoroughly trained physician is worth two half-baked ones"); Dr. Walter Alvarez's warning against too much dependence on laboratory reports ("Are You a Lab Report Worshipper?"); and ex-Congressman Eugene O'Sullivan's vitriolic blast at the entire medical profession (which our Newsvane writer described as "the last quack of a lame duck").

In The Newsvane, too, you'll find *thumbnail statistics*—pertinent figures on such things as doctors' fees, health insurance costs, even the number of miles the average physician drives per year.

Here also is a rich miscellany of *news nuggets*. These tell you about new campaigns being pushed by medical societies, like the one to clean up newspaper health ads in Denver; new gadgets like the alcometer, which "separates the sousers from the sick"; and other new developments in business, politics, and the personal side of medicine.

How do we collect these tidbits? Some of them stem from the 135 periodicals and 104 daily newspapers that our staff combs through each month. An equally important source, however, is our incoming mail—reports from field men, clippings from correspondents, letters from home-town doctors.

More than a few M.E. readers regularly send us local items that they think warrant national publicity. We welcome these; by broadening our scope, they help give The Newsvane its something-for-everyone flavor. —LANSING CHAPMAN

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*For complete information see circular accompanying product.*

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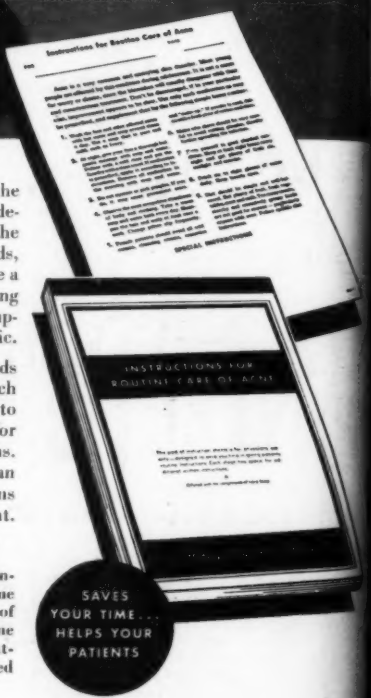


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